

able access to high performing physicians or create financial inequities under such title.

(i) Definitions

In this section:

(1) Eligible professional

The term “eligible professional” has the meaning given that term for purposes of the Physician Quality Reporting Initiative under section 1848 of the Social Security Act (42 U.S.C. 1395w-4).

(2) Physician

The term “physician” has the meaning given that term in section 1861(r) of such Act (42 U.S.C. 1395x(r)).

(3) Physician Compare

The term “Physician Compare” means the Internet website developed under subsection (a)(1).

(4) Secretary

The term “Secretary” means the Secretary of Health and Human Services.

(Pub. L. 111-148, title X, §10331, Mar. 23, 2010, 124 Stat. 966.)

REFERENCES IN TEXT

Section 3014 of this Act, referred to in subsec. (d), is section 3014 of Pub. L. 111-148 which enacted section 1395aaa-1 of this title and amended section 1395aaa of this title.

Section 131 of the Medicare Improvements for Patients and Providers Act of 2008, referred to in subsec. (e), is section 131 of Pub. L. 110-275, 122 Stat. 2520, which amended section 1395w-4 of this title, enacted provisions set out as notes under section 1395w-4 of this title, and redesignated provisions formerly set out as a note under section 1395w-4 of this title as section 1395w-4(m).

The Social Security Act, referred to in subsecs. (g) and (h), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Title XVIII of the Act is classified generally to this subchapter. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

CODIFICATION

Section was enacted as part of the Patient Protection and Affordable Care Act, and not as part of the Social Security Act which comprises this chapter.

§ 1395w-6. Empowering beneficiary choices through continued access to information on physicians’ services

(a) In general

On an annual basis (beginning with 2015), the Secretary shall make publicly available, in an easily understandable format, information with respect to physicians and, as appropriate, other eligible professionals on items and services furnished to Medicare beneficiaries under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(b) Type and manner of information

The information made available under this section shall be similar to the type of information in the Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use File released by the Secretary with respect to 2012 and shall be made available in a manner similar to the manner in which the information in such file is made available.

(c) Requirements

The information made available under this section shall include, at a minimum, the following:

(1) Information on the number of services furnished by the physician or other eligible professional under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.), which may include information on the most frequent services furnished or groupings of services.

(2) Information on submitted charges and payments for services under such part.

(3) A unique identifier for the physician or other eligible professional that is available to the public, such as a national provider identifier.

(d) Searchability

The information made available under this section shall be searchable by at least the following:

(1) The specialty or type of the physician or other eligible professional.

(2) Characteristics of the services furnished, such as volume or groupings of services.

(3) The location of the physician or other eligible professional.

(e) Integration on physician compare

Beginning with 2016, the Secretary shall integrate the information made available under this section on Physician Compare.

(f) Definitions

In this section:

(1) Eligible professional; physician; Secretary

The terms “eligible professional”, “physician”, and “Secretary” have the meaning given such terms in section 1395w-5(i) of this title.

(2) Physician compare

The term “Physician Compare” means the Physician Compare Internet website of the Centers for Medicare & Medicaid Services (or a successor website).

(Pub. L. 114-10, title I, §104, Apr. 16, 2015, 129 Stat. 132.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsecs. (a) and (c)(1), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Title XVIII of the Act is classified generally to this subchapter. Part B of title XVIII of the Act is classified generally to this part. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

CODIFICATION

Section was enacted as part of the Medicare Access and CHIP Reauthorization Act of 2015, and not as part of the Social Security Act which comprises this chapter.

PART C—MEDICARE+CHOICE PROGRAM

PRIOR PROVISIONS

A prior part C of this subchapter, consisting of section 1395x et seq., was redesignated part E of this subchapter.

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate

transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108-173, set out as a note under section 1395w-21 of this title.

§ 1395w-21. Eligibility, election, and enrollment

(a) Choice of medicare benefits through Medicare+Choice plans

(1) In general

Subject to the provisions of this section, each Medicare+Choice eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits (other than qualified prescription drug benefits) under this subchapter—

(A) through the original medicare fee-for-service program under parts A and B of this subchapter, or

(B) through enrollment in a Medicare+Choice plan under this part,

and may elect qualified prescription drug coverage in accordance with section 1395w-101 of this title.

(2) Types of Medicare+Choice plans that may be available

A Medicare+Choice plan may be any of the following types of plans of health insurance:

(A) Coordinated care plans (including regional plans)

(i) In general

Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without point of service options), plans offered by provider-sponsored organizations (as defined in section 1395w-25(d) of this title), and regional or local preferred provider organization plans (including MA regional plans).

(ii) Specialized MA plans for special needs individuals

Specialized MA plans for special needs individuals (as defined in section 1395w-28(b)(6) of this title) may be any type of coordinated care plan.

(B) Combination of MSA plan and contributions to Medicare+Choice MSA

An MSA plan, as defined in section 1395w-28(b)(3) of this title, and a contribution into a Medicare+Choice medical savings account (MSA).

(C) Private fee-for-service plans

A Medicare+Choice private fee-for-service plan, as defined in section 1395w-28(b)(2) of this title.

(3) Medicare+Choice eligible individual

(A) In general

In this subchapter, subject to subparagraph (B), the term “Medicare+Choice eligible individual” means an individual who is entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter.

(B) Special rule for end-stage renal disease

Such term shall not include an individual medically determined to have end-stage renal disease, except that—

(i) an individual who develops end-stage renal disease while enrolled in a Medicare+Choice plan may continue to be enrolled in that plan; and

(ii) in the case of such an individual who is enrolled in a Medicare+Choice plan under clause (i) (or subsequently under this clause), if the enrollment is discontinued under circumstances described in subsection (e)(4)(A) of this section, then the individual will be treated as a “Medicare+Choice eligible individual” for purposes of electing to continue enrollment in another Medicare+Choice plan.

An individual who develops end-stage renal disease while enrolled in a reasonable cost reimbursement contract under section 1395mm(h) of this title shall be treated as an MA eligible individual for purposes of applying the deemed enrollment under subsection (c)(4).

(b) Special rules

(1) Residence requirement

(A) In general

Except as the Secretary may otherwise provide and except as provided in subparagraph (C), an individual is eligible to elect a Medicare+Choice plan offered by a Medicare+Choice organization only if the plan serves the geographic area in which the individual resides.

(B) Continuation of enrollment permitted

Pursuant to rules specified by the Secretary, the Secretary shall provide that an MA local plan may offer to all individuals residing in a geographic area the option to continue enrollment in the plan, notwithstanding that the individual no longer resides in the service area of the plan, so long as the plan provides that individuals exercising this option have, as part of the benefits under the original medicare fee-for-service program option, reasonable access within that geographic area to the full range of basic benefits, subject to reasonable cost sharing liability in obtaining such benefits.

(C) Continuation of enrollment permitted where service changed

Notwithstanding subparagraph (A) and in addition to subparagraph (B), if a Medicare+Choice organization eliminates from its service area a Medicare+Choice payment area that was previously within its service area, the organization may elect to offer individuals residing in all or portions of the affected area who would otherwise be ineligible to continue enrollment the option to continue enrollment in an MA local plan it offers so long as—

(i) the enrollee agrees to receive the full range of basic benefits (excluding emergency and urgently needed care) exclusively at facilities designated by the organization within the plan service area; and

(ii) there is no other Medicare+Choice plan offered in the area in which the enrollee resides at the time of the organization's election.

(2) Special rule for certain individuals covered under FEHBP or eligible for veterans or military health benefits

(A) FEHBP

An individual who is enrolled in a health benefit plan under chapter 89 of title 5 is not eligible to enroll in an MSA plan until such time as the Director of the Office of Management and Budget certifies to the Secretary that the Office of Personnel Management has adopted policies which will ensure that the enrollment of such individuals in such plans will not result in increased expenditures for the Federal Government for health benefit plans under such chapter.

(B) VA and DOD

The Secretary may apply rules similar to the rules described in subparagraph (A) in the case of individuals who are eligible for health care benefits under chapter 55 of title 10 or under chapter 17 of title 38.

(3) Limitation on eligibility of qualified medicare beneficiaries and other medicaid beneficiaries to enroll in an MSA plan

An individual who is a qualified medicare beneficiary (as defined in section 1396d(p)(1) of this title), a qualified disabled and working individual (described in section 1396d(s) of this title), an individual described in section 1396a(a)(10)(E)(iii) of this title, or otherwise entitled to medicare cost-sharing under a State plan under subchapter XIX of this chapter is not eligible to enroll in an MSA plan.

(4) Coverage under MSA plans

(A) In general

Under rules established by the Secretary, an individual is not eligible to enroll (or continue enrollment) in an MSA plan for a year unless the individual provides assurances satisfactory to the Secretary that the individual will reside in the United States for at least 183 days during the year.

(B) Evaluation

The Secretary shall regularly evaluate the impact of permitting enrollment in MSA plans under this part on selection (including adverse selection), use of preventive care, access to care, and the financial status of the Trust Funds under this subchapter.

(C) Reports

The Secretary shall submit to Congress periodic reports on the numbers of individuals enrolled in such plans and on the evaluation being conducted under subparagraph (B).

(c) Process for exercising choice

(1) In general

The Secretary shall establish a process through which elections described in subsection (a) of this section are made and changed, including the form and manner in which such elections are made and changed. Subject to paragraph (4), such elections shall be made or changed only during coverage election periods specified under subsection (e) of this section and shall become effective as provided in subsection (f) of this section.

(2) Coordination through Medicare+Choice organizations

(A) Enrollment

Such process shall permit an individual who wishes to elect a Medicare+Choice plan offered by a Medicare+Choice organization to make such election through the filing of an appropriate election form with the organization.

(B) Disenrollment

Such process shall permit an individual, who has elected a Medicare+Choice plan offered by a Medicare+Choice organization and who wishes to terminate such election, to terminate such election through the filing of an appropriate election form with the organization.

(3) Default

(A) Initial election

(i) In general

Subject to clause (ii), an individual who fails to make an election during an initial election period under subsection (e)(1) of this section is deemed to have chosen the original medicare fee-for-service program option.

(ii) Seamless continuation of coverage

The Secretary may establish procedures under which an individual who is enrolled in a health plan (other than Medicare+Choice plan) offered by a Medicare+Choice organization at the time of the initial election period and who fails to elect to receive coverage other than through the organization is deemed to have elected the Medicare+Choice plan offered by the organization (or, if the organization offers more than one such plan, such plan or plans as the Secretary identifies under such procedures).

(B) Continuing periods

An individual who has made (or is deemed to have made) an election under this section is considered to have continued to make such election until such time as—

- (i) the individual changes the election under this section, or
- (ii) the Medicare+Choice plan with respect to which such election is in effect is discontinued or, subject to subsection (b)(1)(B) of this section, no longer serves the area in which the individual resides.

(4) Deemed enrollment relating to converted reasonable cost reimbursement contracts

(A) In general

On the first day of the annual, coordinated election period under subsection (e)(3) for plan years beginning on or after January 1, 2017, an MA eligible individual described in clause (i) or (ii) of subparagraph (B) is deemed, unless the individual elects otherwise, to have elected to receive benefits under this subchapter through an applicable MA plan (and shall be enrolled in such plan) beginning with such plan year, if—

- (i) the individual is enrolled in a reasonable cost reimbursement contract under

section 1395mm(h) of this title in the previous plan year;

(ii) such reasonable cost reimbursement contract was extended or renewed for the last reasonable cost reimbursement contract year of the contract (as described in subclause (I) of section 1395mm(h)(5)(C)(iv) of this title) pursuant to such section;

(iii) the eligible organization that is offering such reasonable cost reimbursement contract provided the notice described in subclause (III) of such section that the contract was to be converted;

(iv) the applicable MA plan—

(I) is the plan that was converted from the reasonable cost reimbursement contract described in clause (iii);

(II) is offered by the same entity (or an organization affiliated with such entity that has a common ownership interest of control) that entered into such contract; and

(III) is offered in the service area where the individual resides;

(v) in the case of reasonable cost reimbursement contracts that provide coverage under parts A and B (and, to the extent the Secretary determines it to be feasible, contracts that provide only part B coverage), the difference between the estimated individual costs (as determined applicable by the Secretary) for the applicable MA plan and such costs for the predecessor cost plan does not exceed a threshold established by the Secretary; and

(vi) the applicable MA plan—

(I) provides coverage for enrollees transitioning from the converted reasonable cost reimbursement contract to such plan to maintain current providers of services and suppliers and course of treatment at the time of enrollment for a period of at least 90 days after enrollment; and

(II) during such period, pays such providers of services and suppliers for items and services furnished to the enrollee an amount that is not less than the amount of payment applicable for such items and services under the original Medicare fee-for-service program under parts A and B.

(B) MA eligible individuals described

(i) Without prescription drug coverage

An MA eligible individual described in this clause, with respect to a plan year, is an MA eligible individual who is enrolled in a reasonable cost reimbursement contract under section 1395mm(h) of this title in the previous plan year and who is not, for such previous plan year, enrolled in a prescription drug plan under part D, including coverage under section 1395w-132 of this title.

(ii) With prescription drug coverage

An MA eligible individual described in this clause, with respect to a plan year, is an MA eligible individual who is enrolled in a reasonable cost reimbursement contract under section 1395mm(h) of this title

in the previous plan year and who, for such previous plan year, is enrolled in a prescription drug plan under part D—

(I) through such contract; or

(II) through a prescription drug plan, if the sponsor of such plan is the same entity (or an organization affiliated with such entity) that entered into such contract.

(C) Applicable MA plan defined

In this paragraph, the term “applicable MA plan” means, in the case of an individual described in—

(i) subparagraph (B)(i), an MA plan that is not an MA-PD plan; and

(ii) subparagraph (B)(ii), an MA-PD plan.

(D) Identification and notification of deemed individuals

Not later than 45 days before the first day of the annual, coordinated election period under subsection (e)(3) for plan years beginning on or after January 1, 2017, the Secretary shall identify and notify the individuals who will be subject to deemed elections under subparagraph (A) on the first day of such period.

(d) Providing information to promote informed choice

(1) In general

The Secretary shall provide for activities under this subsection to broadly disseminate information to medicare beneficiaries (and prospective medicare beneficiaries) on the coverage options provided under this section in order to promote an active, informed selection among such options.

(2) Provision of notice

(A) Open season notification

At least 15 days before the beginning of each annual, coordinated election period (as defined in subsection (e)(3)(B) of this section), the Secretary shall mail to each Medicare+Choice eligible individual residing in an area the following:

(i) General information

The general information described in paragraph (3).

(ii) List of plans and comparison of plan options

A list identifying the Medicare+Choice plans that are (or will be) available to residents of the area and information described in paragraph (4) concerning such plans. Such information shall be presented in a comparative form.

(iii) Additional information

Any other information that the Secretary determines will assist the individual in making the election under this section.

The mailing of such information shall be coordinated, to the extent practicable, with the mailing of any annual notice under section 1395b-2 of this title.

(B) Notifications required**(i) Notification to newly eligible Medicare Advantage eligible individuals**

To the extent practicable, the Secretary shall, not later than 30 days before the beginning of the initial Medicare+Choice enrollment period for an individual described in subsection (e)(1) of this section, mail to the individual the information described in subparagraph (A).

(ii) Notification related to certain deemed elections

The Secretary shall require a Medicare Advantage organization that is offering a Medicare Advantage plan that has been converted from a reasonable cost reimbursement contract pursuant to section 1395mm(h)(5)(C)(iv) of this title to mail, not later than 30 days prior to the first day of the annual, coordinated election period under subsection (e)(3) of a year, to any individual enrolled under such contract and identified by the Secretary under subsection (c)(4)(D) for such year—

(I) a notification that such individual will, on such day, be deemed to have made an election with respect to such plan to receive benefits under this subchapter through an MA plan or MA-PD plan (and shall be enrolled in such plan) for the next plan year under subsection (c)(4)(A), but that the individual may make a different election during the annual, coordinated election period for such year;

(II) the information described in subparagraph (A);

(III) a description of the differences between such MA plan or MA-PD plan and the reasonable cost reimbursement contract in which the individual was most recently enrolled with respect to benefits covered under such plans, including cost-sharing, premiums, drug coverage, and provider networks;

(IV) information about the special period for elections under subsection (e)(2)(F); and

(V) other information the Secretary may specify.

(C) Form

The information disseminated under this paragraph shall be written and formatted using language that is easily understandable by medicare beneficiaries.

(D) Periodic updating

The information described in subparagraph (A) shall be updated on at least an annual basis to reflect changes in the availability of Medicare+Choice plans and the benefits and Medicare+Choice monthly basic and supplemental beneficiary premiums for such plans.

(3) General information

General information under this paragraph, with respect to coverage under this part during a year, shall include the following:

(A) Benefits under original medicare fee-for-service program option

A general description of the benefits covered under the original medicare fee-for-service program under parts A and B of this subchapter, including—

(i) covered items and services,

(ii) beneficiary cost sharing, such as deductibles, coinsurance, and copayment amounts, and

(iii) any beneficiary liability for balance billing.

(B) Election procedures

Information and instructions on how to exercise election options under this section.

(C) Rights

A general description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program and the Medicare+Choice program and the right to be protected against discrimination based on health status-related factors under section 1395w-22(b) of this title.

(D) Information on medigap and medicare select

A general description of the benefits, enrollment rights, and other requirements applicable to medicare supplemental policies under section 1395ss of this title and provisions relating to medicare select policies described in section 1395ss(t) of this title.

(E) Potential for contract termination

The fact that a Medicare+Choice organization may terminate its contract, refuse to renew its contract, or reduce the service area included in its contract, under this part, and the effect of such a termination, nonrenewal, or service area reduction may have on individuals enrolled with the Medicare+Choice plan under this part.

(F) Catastrophic coverage and single deductible

In the case of an MA regional plan, a description of the catastrophic coverage and single deductible applicable under the plan.

(4) Information comparing plan options

Information under this paragraph, with respect to a Medicare+Choice plan for a year, shall include the following:

(A) Benefits

The benefits covered under the plan, including the following:

(i) Covered items and services beyond those provided under the original medicare fee-for-service program.

(ii) Any beneficiary cost sharing, including information on the single deductible (if applicable) under section 1395w-27a(b)(1) of this title.

(iii) Any maximum limitations on out-of-pocket expenses.

(iv) In the case of an MSA plan, differences in cost sharing, premiums, and balance billing under such a plan compared to under other Medicare+Choice plans.

(v) In the case of a Medicare+Choice private fee-for-service plan, differences in cost sharing, premiums, and balance billing under such a plan compared to under other Medicare+Choice plans.

(vi) The extent to which an enrollee may obtain benefits through out-of-network health care providers.

(vii) The extent to which an enrollee may select among in-network providers and the types of providers participating in the plan's network.

(viii) The organization's coverage of emergency and urgently needed care.

(B) Premiums

(i) In general

The monthly amount of the premium charged to an individual.

(ii) Reductions

The reduction in part B premiums, if any.

(C) Service area

The service area of the plan.

(D) Quality and performance

To the extent available, plan quality and performance indicators for the benefits under the plan (and how they compare to such indicators under the original medicare fee-for-service program under parts A and B of this subchapter in the area involved), including—

(i) disenrollment rates for medicare enrollees electing to receive benefits through the plan for the previous 2 years (excluding disenrollment due to death or moving outside the plan's service area),

(ii) information on medicare enrollee satisfaction,

(iii) information on health outcomes, and

(iv) the recent record regarding compliance of the plan with requirements of this part (as determined by the Secretary).

(E) Supplemental benefits

Supplemental health care benefits, including any reductions in cost-sharing under section 1395w-22(a)(3) of this title and the terms and conditions (including premiums) for such benefits.

(5) Maintaining a toll-free number and Internet site

The Secretary shall maintain a toll-free number for inquiries regarding Medicare+Choice options and the operation of this part in all areas in which Medicare+Choice plans are offered and an Internet site through which individuals may electronically obtain information on such options and Medicare+Choice plans.

(6) Use of non-Federal entities

The Secretary may enter into contracts with non-Federal entities to carry out activities under this subsection.

(7) Provision of information

A Medicare+Choice organization shall provide the Secretary with such information on

the organization and each Medicare+Choice plan it offers as may be required for the preparation of the information referred to in paragraph (2)(A).

(e) Coverage election periods

(1) Initial choice upon eligibility to make election if Medicare+Choice plans available to individual

If, at the time an individual first becomes entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter, there is one or more Medicare+Choice plans offered in the area in which the individual resides, the individual shall make the election under this section during a period specified by the Secretary such that if the individual elects a Medicare+Choice plan during the period, coverage under the plan becomes effective as of the first date on which the individual may receive such coverage. If any portion of an individual's initial enrollment period under part B of this subchapter occurs after the end of the annual, coordinated election period described in paragraph (3)(B)(iii), the initial enrollment period under this part shall further extend through the end of the individual's initial enrollment period under part B of this subchapter.

(2) Open enrollment and disenrollment opportunities

Subject to paragraph (5)—

(A) Continuous open enrollment and disenrollment through 2005

At any time during the period beginning January 1, 1998, and ending on December 31, 2005, a Medicare+Choice eligible individual may change the election under subsection (a)(1) of this section.

(B) Continuous open enrollment and disenrollment for first 6 months during 2006

(i) In general

Subject to clause (ii), subparagraph (C)(iii),¹ and subparagraph (D), at any time during the first 6 months of 2006, or, if the individual first becomes a Medicare+Choice eligible individual during 2006, during the first 6 months during 2006 in which the individual is a Medicare+Choice eligible individual, a Medicare+Choice eligible individual may change the election under subsection (a)(1) of this section.

(ii) Limitation of one change

An individual may exercise the right under clause (i) only once. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under the first sentence of paragraph (4).

¹ See References in Text note below.

(C) Annual 45-day period for disenrollment from MA plans to elect to receive benefits under the original Medicare fee-for-service program

Subject to subparagraph (D), at any time during the first 45 days of a year (beginning with 2011), an individual who is enrolled in a Medicare Advantage plan may change the election under subsection (a)(1), but only with respect to coverage under the original Medicare fee-for-service program under parts A and B, and may elect qualified prescription drug coverage in accordance with section 1395w-101 of this title.

(D) Continuous open enrollment for institutionalized individuals

At any time after 2005 in the case of a Medicare+Choice eligible individual who is institutionalized (as defined by the Secretary), the individual may elect under subsection (a)(1) of this section—

- (i) to enroll in a Medicare+Choice plan; or
- (ii) to change the Medicare+Choice plan in which the individual is enrolled.

(E) Limited continuous open enrollment of original fee-for-service enrollees in Medicare advantage non-prescription drug plans

(i) In general

On any date during the period beginning on January 1, 2007, and ending on July 31, 2007, on which a Medicare Advantage eligible individual is an unenrolled fee-for-service individual (as defined in clause (ii)), the individual may elect under subsection (a)(1) to enroll in a Medicare Advantage plan that is not an MA-PD plan.

(ii) Unenrolled fee-for-service individual defined

In this subparagraph, the term “unenrolled fee-for-service individual” means, with respect to a date, a Medicare Advantage eligible individual who—

- (I) is receiving benefits under this subchapter through enrollment in the original Medicare fee-for-service program under parts A and B;
- (II) is not enrolled in an MA plan on such date; and
- (III) as of such date is not otherwise eligible to elect to enroll in an MA plan.

(iii) Limitation of one change during the applicable period

An individual may exercise the right under clause (i) only once during the period described in such clause.

(iv) No effect on coverage under a prescription drug plan

Nothing in this subparagraph shall be construed as permitting an individual exercising the right under clause (i)—

- (I) who is enrolled in a prescription drug plan under part D, to disenroll from such plan or to enroll in a different prescription drug plan; or
- (II) who is not enrolled in a prescription drug plan, to enroll in such a plan.

(F) Special period for certain deemed elections

(i) In general

At any time during the period beginning after the last day of the annual, coordinated election period under paragraph (3) in which an individual is deemed to have elected to enroll in an MA plan or MA-PD plan under subsection (c)(4) and ending on the last day of February of the first plan year for which the individual is enrolled in such plan, such individual may change the election under subsection (a)(1) (including changing the MA plan or MA-PD plan in which the individual is enrolled).

(ii) Limitation of one change

An individual may exercise the right under clause (i) only once during the applicable period described in such clause. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

(3) Annual, coordinated election period

(A) In general

Subject to paragraph (5), each individual who is eligible to make an election under this section may change such election during an annual, coordinated election period.

(B) Annual, coordinated election period

For purposes of this section, the term “annual, coordinated election period” means—

- (i) with respect to a year before 2002, the month of November before such year;
- (ii) with respect to 2002, 2003, 2004, and 2005, the period beginning on November 15 and ending on December 31 of the year before such year;
- (iii) with respect to 2006, the period beginning on November 15, 2005, and ending on May 15, 2006;
- (iv) with respect to 2007, 2008, 2009, and 2010, the period beginning on November 15 and ending on December 31 of the year before such year; and
- (v) with respect to 2012 and succeeding years, the period beginning on October 15 and ending on December 7 of the year before such year.

(C) Medicare+Choice health information fairs

During the fall season of each year (beginning with 1999) and during the period described in subparagraph (B)(iii), in conjunction with the annual coordinated election period defined in subparagraph (B), the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform Medicare+Choice eligible individuals about Medicare+Choice plans and the election process provided under this section.

(D) Special information campaigns

During November 1998 the Secretary shall provide for an educational and publicity campaign to inform Medicare+Choice eligible individuals about the availability of Medicare+Choice plans, and eligible organi-

zations with risk-sharing contracts under section 1395mm of this title, offered in different areas and the election process provided under this section. During the period described in subparagraph (B)(iii), the Secretary shall provide for an educational and publicity campaign to inform MA eligible individuals about the availability of MA plans (including MA-PD plans) offered in different areas and the election process provided under this section.

(4) Special election periods

Effective as of January 1, 2006, an individual may discontinue an election of a Medicare+Choice plan offered by a Medicare+Choice organization other than during an annual, coordinated election period and make a new election under this section if—

(A)(i) the certification of the organization or plan under this part has been terminated, or the organization or plan has notified the individual of an impending termination of such certification; or

(ii) the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuation of such plan;

(B) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances (specified by the Secretary, but not including termination of the individual's enrollment on the basis described in clause (i) or (ii) of subsection (g)(3)(B) of this section);

(C) the individual demonstrates (in accordance with guidelines established by the Secretary) that—

(i) the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual (including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards); or

(ii) the organization (or an agent or other entity acting on the organization's behalf) materially misrepresented the plan's provisions in marketing the plan to the individual; or

(D) the individual meets such other exceptional conditions as the Secretary may provide.

Effective as of January 1, 2006, an individual who, upon first becoming eligible for benefits under part A of this subchapter at age 65, enrolls in a Medicare+Choice plan under this part, the individual may discontinue the election of such plan, and elect coverage under the original fee-for-service plan, at any time during the 12-month period beginning on the effective date of such enrollment.

(5) Special rules for MSA plans

Notwithstanding the preceding provisions of this subsection, an individual—

(A) may elect an MSA plan only during—
(i) an initial open enrollment period described in paragraph (1), or

(ii) an annual, coordinated election period described in paragraph (3)(B);

(B) subject to subparagraph (C), may not discontinue an election of an MSA plan except during the periods described in clause (ii) or (iii) of subparagraph (A) and under the first sentence of paragraph (4); and

(C) who elects an MSA plan during an annual, coordinated election period, and who never previously had elected such a plan, may revoke such election, in a manner determined by the Secretary, by not later than December 15 following the date of the election.

(6) Open enrollment periods

Subject to paragraph (5), a Medicare+Choice organization—

(A) shall accept elections or changes to elections during the initial enrollment periods described in paragraph (1), during the period described in paragraph (2)(F), during the month of November 1998 and during the annual, coordinated election period under paragraph (3) for each subsequent year, and during special election periods described in the first sentence of paragraph (4); and

(B) may accept other changes to elections at such other times as the organization provides.

(f) Effectiveness of elections and changes of elections

(1) During initial coverage election period

An election of coverage made during the initial coverage election period under subsection (e)(1) of this section shall take effect upon the date the individual becomes entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter, except as the Secretary may provide (consistent with section 1395q of this title) in order to prevent retroactive coverage.

(2) During continuous open enrollment periods

An election or change of coverage made under subsection (e)(2) of this section shall take effect with the first day of the first calendar month following the date on which the election or change is made.

(3) Annual, coordinated election period

An election or change of coverage made during an annual, coordinated election period (as defined in subsection (e)(3)(B) of this section, other than the period described in clause (iii) of such subsection) in a year shall take effect as of the first day of the following year.

(4) Other periods

An election or change of coverage made during any other period under subsection (e)(4) of this section shall take effect in such manner as the Secretary provides in a manner consistent (to the extent practicable) with protecting continuity of health benefit coverage.

(g) Guaranteed issue and renewal

(1) In general

Except as provided in this subsection, a Medicare+Choice organization shall provide

that at any time during which elections are accepted under this section with respect to a Medicare+Choice plan offered by the organization, the organization will accept without restrictions individuals who are eligible to make such election.

(2) Priority

If the Secretary determines that a Medicare+Choice organization, in relation to a Medicare+Choice plan it offers, has a capacity limit and the number of Medicare+Choice eligible individuals who elect the plan under this section exceeds the capacity limit, the organization may limit the election of individuals of the plan under this section but only if priority in election is provided—

(A) first to such individuals as have elected the plan at the time of the determination, and

(B) then to other such individuals in such a manner that does not discriminate, on a basis described in section 1395w-22(b) of this title, among the individuals (who seek to elect the plan).

The preceding sentence shall not apply if it would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the medicare population in the service area of the plan.

(3) Limitation on termination of election

(A) In general

Subject to subparagraph (B), a Medicare+Choice organization may not for any reason terminate the election of any individual under this section for a Medicare+Choice plan it offers.

(B) Basis for termination of election

A Medicare+Choice organization may terminate an individual's election under this section with respect to a Medicare+Choice plan it offers if—

(i) any Medicare+Choice monthly basic and supplemental beneficiary premiums required with respect to such plan are not paid on a timely basis (consistent with standards under section 1395w-26 of this title that provide for a grace period for late payment of such premiums),

(ii) the individual has engaged in disruptive behavior (as specified in such standards), or

(iii) the plan is terminated with respect to all individuals under this part in the area in which the individual resides.

(C) Consequence of termination

(i) Terminations for cause

Any individual whose election is terminated under clause (i) or (ii) of subparagraph (B) is deemed to have elected the original medicare fee-for-service program option described in subsection (a)(1)(A) of this section.

(ii) Termination based on plan termination or service area reduction

Any individual whose election is terminated under subparagraph (B)(iii) shall

have a special election period under subsection (e)(4)(A) of this section in which to change coverage to coverage under another Medicare+Choice plan. Such an individual who fails to make an election during such period is deemed to have chosen to change coverage to the original medicare fee-for-service program option described in subsection (a)(1)(A) of this section.

(D) Organization obligation with respect to election forms

Pursuant to a contract under section 1395w-27 of this title, each Medicare+Choice organization receiving an election form under subsection (c)(2) of this section shall transmit to the Secretary (at such time and in such manner as the Secretary may specify) a copy of such form or such other information respecting the election as the Secretary may specify.

(h) Approval of marketing material and application forms

(1) Submission

No marketing material or application form may be distributed by a Medicare+Choice organization to (or for the use of) Medicare+Choice eligible individuals unless—

(A) at least 45 days (or 10 days in the case described in paragraph (5)) before the date of distribution the organization has submitted the material or form to the Secretary for review, and

(B) the Secretary has not disapproved the distribution of such material or form.

(2) Review

The standards established under section 1395w-26 of this title shall include guidelines for the review of any material or form submitted and under such guidelines the Secretary shall disapprove (or later require the correction of) such material or form if the material or form is materially inaccurate or misleading or otherwise makes a material misrepresentation.

(3) Deemed approval (1-stop shopping)

In the case of material or form that is submitted under paragraph (1)(A) to the Secretary or a regional office of the Department of Health and Human Services and the Secretary or the office has not disapproved the distribution of marketing material or form under paragraph (1)(B) with respect to a Medicare+Choice plan in an area, the Secretary is deemed not to have disapproved such distribution in all other areas covered by the plan and organization except with regard to that portion of such material or form that is specific only to an area involved.

(4) Prohibition of certain marketing practices

Each Medicare+Choice organization shall conform to fair marketing standards, in relation to Medicare+Choice plans offered under this part, included in the standards established under section 1395w-26 of this title. Such standards—

(A) shall not permit a Medicare+Choice organization to provide for, subject to sub-

section (j)(2)(C), cash, gifts, prizes, or other monetary rebates as an inducement for enrollment or otherwise;

(B) may include a prohibition against a Medicare+Choice organization (or agent of such an organization) completing any portion of any election form used to carry out elections under this section on behalf of any individual;

(C) shall not permit a Medicare Advantage organization (or the agents, brokers, and other third parties representing such organization) to conduct the prohibited activities described in subsection (j)(1); and

(D) shall only permit a Medicare Advantage organization (and the agents, brokers, and other third parties representing such organization) to conduct the activities described in subsection (j)(2) in accordance with the limitations established under such subsection.

(5) Special treatment of marketing material following model marketing language

In the case of marketing material of an organization that uses, without modification, proposed model language specified by the Secretary, the period specified in paragraph (1)(A) shall be reduced from 45 days to 10 days.

(6) Required inclusion of plan type in plan name

For plan years beginning on or after January 1, 2010, a Medicare Advantage organization must ensure that the name of each Medicare Advantage plan offered by the Medicare Advantage organization includes the plan type of the plan (using standard terminology developed by the Secretary).

(7) Strengthening the ability of States to act in collaboration with the Secretary to address fraudulent or inappropriate marketing practices

(A) Appointment of agents and brokers

Each Medicare Advantage organization shall—

(i) only use agents and brokers who have been licensed under State law to sell Medicare Advantage plans offered by the Medicare Advantage organization;

(ii) in the case where a State has a State appointment law, abide by such law; and

(iii) report to the applicable State the termination of any such agent or broker, including the reasons for such termination (as required under applicable State law).

(B) Compliance with State information requests

Each Medicare Advantage organization shall comply in a timely manner with any request by a State for information regarding the performance of a licensed agent, broker, or other third party representing the Medicare Advantage organization as part of an investigation by the State into the conduct of the agent, broker, or other third party.

(i) Effect of election of Medicare+Choice plan option

(1) Payments to organizations

Subject to sections 1395w-22(a)(5), 1395w-23(a)(4), 1395w-23(g), 1395w-23(h),

1395ww(d)(11), 1395ww(h)(3)(D), and 1395w-23(m) of this title, payments under a contract with a Medicare+Choice organization under section 1395w-23(a) of this title with respect to an individual electing a Medicare+Choice plan offered by the organization shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under parts A and B of this subchapter for items and services furnished to the individual.

(2) Only organization entitled to payment

Subject to sections 1395w-23(a)(4), 1395w-23(e), 1395w-23(g), 1395w-23(h), 1395w-27(f)(2), 1395w-27a(h), 1395ww(d)(11), and 1395ww(h)(3)(D) of this title, only the Medicare+Choice organization shall be entitled to receive payments from the Secretary under this subchapter for services furnished to the individual.

(j) Prohibited activities described and limitations on the conduct of certain other activities

(1) Prohibited activities described

The following prohibited activities are described in this paragraph:

(A) Unsolicited means of direct contact

Any unsolicited means of direct contact of prospective enrollees, including soliciting door-to-door or any outbound telemarketing without the prospective enrollee initiating contact.

(B) Cross-selling

The sale of other non-health related products (such as annuities and life insurance) during any sales or marketing activity or presentation conducted with respect to a Medicare Advantage plan.

(C) Meals

The provision of meals of any sort, regardless of value, to prospective enrollees at promotional and sales activities.

(D) Sales and marketing in health care settings and at educational events

Sales and marketing activities for the enrollment of individuals in Medicare Advantage plans that are conducted—

(i) in health care settings in areas where health care is delivered to individuals (such as physician offices and pharmacies), except in the case where such activities are conducted in common areas in health care settings; and

(ii) at educational events.

(2) Limitations

The Secretary shall establish limitations with respect to at least the following:

(A) Scope of marketing appointments

The scope of any appointment with respect to the marketing of a Medicare Advantage plan. Such limitation shall require advance agreement with a prospective enrollee on the scope of the marketing appointment and documentation of such agreement by the Medicare Advantage organization. In the case where the marketing appointment is in

person, such documentation shall be in writing.

(B) Co-branding

The use of the name or logo of a co-branded network provider on Medicare Advantage plan membership and marketing materials.

(C) Limitation of gifts to nominal dollar value

The offering of gifts and other promotional items other than those that are of nominal value (as determined by the Secretary) to prospective enrollees at promotional activities.

(D) Compensation

The use of compensation other than as provided under guidelines established by the Secretary. Such guidelines shall ensure that the use of compensation creates incentives for agents and brokers to enroll individuals in the Medicare Advantage plan that is intended to best meet their health care needs.

(E) Required training, annual retraining, and testing of agents, brokers, and other third parties

The use by a Medicare Advantage organization of any individual as an agent, broker, or other third party representing the organization that has not completed an initial training and testing program and does not complete an annual retraining and testing program.

(Aug. 14, 1935, ch. 531, title XVIII, § 1851, as added Pub. L. 105-33, title IV, § 4001, Aug. 5, 1997, 111 Stat. 275; amended Pub. L. 106-113, div. B, § 1000(a)(6) [title III, § 321(k)(6)(A), title V, §§ 501(a)(1), (b), (c), 502(a), 519(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A-367, 1501A-378 to 1501A-380, 1501A-385; Pub. L. 106-554, § 1(a)(6) [title VI, §§ 606(a)(2)(C), 613(a), 619(a), 620(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A-558, 2763A-560, 2763A-563; Pub. L. 107-188, title V, § 532(a), (c)(1), June 12, 2002, 116 Stat. 696; Pub. L. 108-173, title I, § 102(a), (c)(1), title II, §§ 221(a)(1), (d)(5), 222(l)(3)(A), (B), (D), (E), 231(a), 233(b), (d), 237(b)(2)(A), Dec. 8, 2003, 117 Stat. 2152, 2154, 2180, 2193, 2206, 2207, 2209, 2212; Pub. L. 109-432, div. B, title II, § 206(a), Dec. 20, 2006, 120 Stat. 2990; Pub. L. 110-48, § 2, July 18, 2007, 121 Stat. 244; Pub. L. 110-275, title I, § 103(a)(1), (b)(1), (c)(1), (d)(1), July 15, 2008, 122 Stat. 2498-2501; Pub. L. 111-5, div. B, title IV, § 4102(d)(2), Feb. 17, 2009, 123 Stat. 486; Pub. L. 111-148, title III, §§ 3201(e)(2)(A)(i), 3204(a)(1), (b), Mar. 23, 2010, 124 Stat. 446, 456; Pub. L. 111-152, title I, § 1102(a), Mar. 30, 2010, 124 Stat. 1040; Pub. L. 114-10, title II, § 209(b)(1)-(2)(B)(i), (3), (c), Apr. 16, 2015, 129 Stat. 147-150.)

REFERENCES IN TEXT

Subsec. (e)(2)(C) of this section, referred to in subsec. (e)(2)(B)(i), was amended generally by section 3204(a)(1) of Pub. L. 111-148 and, as so amended, no longer contains a cl. (iii).

AMENDMENTS

2015—Subsec. (a)(3)(B). Pub. L. 114-10, § 209(b)(3), inserted concluding provisions.

Subsec. (c)(1). Pub. L. 114-10, § 209(b)(1)(A), substituted “Subject to paragraph (4), such elections” for “Such elections”.

Subsec. (c)(4). Pub. L. 114-10, § 209(b)(1)(B), added par. (4).

Subsec. (d)(2)(B). Pub. L. 114-10, § 209(c), designated existing provisions as cl. (i), inserted heading, and added cl. (ii).

Pub. L. 114-10, § 209(c)(1), which directed the substitution of “Notifications required” for “Notification to newly eligible medicare advantage eligible individuals” in heading, was executed by making the substitution for “Notification to newly eligible Medicare+Choice eligible individuals” to reflect the probable intent of Congress.

Subsec. (e)(2)(F). Pub. L. 114-10, § 209(b)(2)(A), added subpar. (F).

Subsec. (e)(6)(A). Pub. L. 114-10, § 209(b)(2)(B)(i), substituted “paragraph (1), during the period described in paragraph (2)(F),” for “paragraph (1),”.

2010—Subsec. (b)(1)(C). Pub. L. 111-148, § 3201(e)(2)(A)(i), which directed that subpar. (C) be struck out, was repealed by Pub. L. 111-152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (e)(2)(C). Pub. L. 111-148, § 3204(a)(1), amended subpar. (C) generally. Prior to amendment, subpar. (C) related to continuous open enrollment and disenrollment for first 3 months of a year after 2006.

Subsec. (e)(3)(B)(iv). Pub. L. 111-148, § 3204(b)(2)(A), substituted “, 2008, 2009, and 2010” for “and succeeding years”.

Subsec. (e)(3)(B)(v). Pub. L. 111-148, § 3204(b)(1), (2)(B), (3), added cl. (v).

2009—Subsec. (i)(1). Pub. L. 111-5 substituted “1395ww(h)(3)(D), and 1395w-23(m)” for “and 1395ww(h)(3)(D)”.

2008—Subsec. (h)(4)(A). Pub. L. 110-275, § 103(a)(1)(A)(i)(I)(aa), substituted “, subject to subsection (j)(2)(C), cash, gifts, prizes, or other monetary rebates” for “cash or other monetary rebates”.

Subsec. (h)(4)(C). Pub. L. 110-275, § 103(a)(1)(A)(i)(I)(bb)-(III), added subpar. (C).

Subsec. (h)(4)(D). Pub. L. 110-275, § 103(b)(1)(A), added subpar. (D).

Subsec. (h)(6). Pub. L. 110-275, § 103(c)(1), added par. (6).

Subsec. (h)(7). Pub. L. 110-275, § 103(d)(1), added par. (7).

Subsec. (j). Pub. L. 110-275, § 103(a)(1)(A)(ii), added subsec. (j).

Subsec. (j)(2). Pub. L. 110-275, § 103(b)(1)(B), added par. (2).

2007—Subsec. (e)(2)(E)(i). Pub. L. 110-48, § 2(1), substituted “the period beginning on January 1, 2007, and ending on July 31, 2007,” for “2007 or 2008”.

Subsec. (e)(2)(E)(iii). Pub. L. 110-48, § 2(2), substituted “the applicable period” for “year” in heading and “the period described in such clause” for “the year” in text.

2006—Subsec. (e)(2)(E). Pub. L. 109-432 added subpar. (E).

2003—Subsec. (a)(1). Pub. L. 108-173, § 102(c)(1)(A), (C), inserted “(other than qualified prescription drug benefits)” after “benefits” in introductory provisions and inserted concluding provisions.

Subsec. (a)(1)(B). Pub. L. 108-173, § 102(c)(1)(B), substituted comma for period at end.

Subsec. (a)(2)(A). Pub. L. 108-173, § 221(a)(1), substituted “Coordinated care plans (including regional plans)” for “Coordinated care plans” in heading, inserted cl. (i) designation and heading before “Coordinated”, and inserted “regional or local” before “preferred provider organization plans” and “(including MA regional plans)” before period at end.

Subsec. (a)(2)(A)(ii). Pub. L. 108-173, § 231(a), added cl. (ii).

Subsec. (a)(3)(B)(ii). Pub. L. 108-173, § 222(l)(3)(D), made technical amendment to reference in original act which appears in text as reference to subsection (e)(4)(A) of this section.

Subsec. (b)(1)(B). Pub. L. 108-173, § 222(l)(3)(A)(i), (ii), substituted “an MA local plan” for “a plan” and “benefits under the original medicare fee-for-service program option” for “basic benefits described in section 1395w-22(a)(1)(A) of this title”.

Subsec. (b)(1)(C). Pub. L. 108-173, § 222(l)(3)(A)(iii), substituted “in an MA local plan” for “in a Medicare+Choice plan” in introductory provisions.

Subsec. (b)(4). Pub. L. 108-173, § 233(b)(1), struck out “on a demonstration basis” after “plans” in heading.

Subsec. (b)(4)(A). Pub. L. 108-173, § 233(b)(2), struck out first sentence which read as follows: “An individual is not eligible to enroll in an MSA plan under this part—

“(i) on or after January 1, 2003, unless the enrollment is the continuation of such an enrollment in effect as of such date; or

“(ii) as of any date if the number of such individuals so enrolled as of such date has reached 390,000.” Subsec. (b)(4)(C). Pub. L. 108-173, § 233(b)(3), struck out at end “The Secretary shall submit such a report, by not later than March 1, 2002, on whether the time limitation under subparagraph (A)(i) should be extended or removed and whether to change the numerical limitation under subparagraph (A)(ii).”

Subsec. (d)(3)(F). Pub. L. 108-173, § 222(l)(3)(B)(i), added subpar. (F).

Subsec. (d)(4)(A)(ii). Pub. L. 108-173, § 222(l)(3)(B)(ii), inserted “, including information on the single deductible (if applicable) under section 1395w-27a(b)(1) of this title” after “cost sharing”.

Subsec. (d)(4)(B)(i). Pub. L. 108-173, § 222(l)(3)(B)(iii), substituted “monthly amount of the premium charged to an individual” for “Medicare+Choice monthly basic beneficiary premium and Medicare+Choice monthly supplemental beneficiary premium, if any, for the plan or, in the case of an MSA plan, the Medicare+Choice monthly MSA premium”.

Subsec. (d)(4)(E). Pub. L. 108-173, § 222(l)(3)(B)(iv), reenacted heading without change and amended text generally. Prior to amendment, text read as follows: “Whether the organization offering the plan includes mandatory supplemental benefits in its base benefit package or offers optional supplemental benefits and the terms and conditions (including premiums) for such coverage.”

Subsec. (e)(1). Pub. L. 108-173, § 102(a)(4), inserted at end “If any portion of an individual’s initial enrollment period under part B of this subchapter occurs after the end of the annual, coordinated election period described in paragraph (3)(B)(iii), the initial enrollment period under this part shall further extend through the end of the individual’s initial enrollment period under part B of this subchapter.”

Subsec. (e)(2). Pub. L. 108-173, § 102(a)(1)(A), substituted “2005” and “2006” for “2004” and “2005”, respectively, wherever appearing.

Subsec. (e)(2)(B)(i). Pub. L. 108-173, § 102(a)(6)(A), inserted “, subparagraph (C)(iii),” after “clause (ii)”.

Subsec. (e)(2)(C)(i). Pub. L. 108-173, § 102(a)(6)(B), substituted “clauses (i) and (iii)” for “clause (ii)”.

Subsec. (e)(2)(C)(iii). Pub. L. 108-173, § 102(a)(6)(C), added cl. (iii).

Subsec. (e)(3)(B). Pub. L. 108-173, § 102(a)(2), reenacted heading without change and amended text generally. Prior to amendment, text read as follows: “For purposes of this section, the term ‘annual, coordinated election period’ means, with respect to a year before 2003 and after 2005, the month of November before such year and with respect to 2003, 2004, and 2005, the period beginning on November 15 and ending on December 31 of the year before such year.”

Subsec. (e)(3)(C). Pub. L. 108-173, § 102(a)(3)(A), inserted “and during the period described in subparagraph (B)(iii)” after “(beginning with 1999)”.

Subsec. (e)(3)(D). Pub. L. 108-173, § 102(a)(3)(B), in heading, substituted “campaigns” for “campaign in 1998” and, in text, inserted at end “During the period described in subparagraph (B)(iii), the Secretary shall provide for an educational and publicity campaign to inform MA eligible individuals about the availability of MA plans (including MA-PD plans) offered in different areas and the election process provided under this section.”

Subsec. (e)(4). Pub. L. 108-173, § 102(a)(1)(B), substituted “2006” for “2005” in two places.

Subsec. (e)(5)(A)(i). Pub. L. 108-173, § 233(d)(1), inserted “or” at end.

Subsec. (e)(5)(A)(ii). Pub. L. 108-173, § 233(d)(2), substituted semicolon for “, or”.

Subsec. (e)(5)(A)(iii). Pub. L. 108-173, § 233(d)(3), struck out cl. (iii) which read as follows: “the month of November 1998;”.

Subsec. (f)(1). Pub. L. 108-173, § 222(l)(3)(E), substituted “subsection (e)(1)” for “subsection (e)(1)(A)”.

Subsec. (f)(3). Pub. L. 108-173, § 102(a)(5), inserted “, other than the period described in clause (iii) of such subsection” after “subsection (e)(3)(B) of this section”.

Subsec. (i)(1). Pub. L. 108-173, § 237(b)(2)(A)(i), inserted “1395w-23(a)(4),” after “Subject to sections 1395w-22(a)(5),”.

Subsec. (i)(2). Pub. L. 108-173, § 237(b)(2)(A)(ii), inserted “1395w-23(a)(4),” after “Subject to sections”.

Pub. L. 108-173, § 221(d)(5), inserted “1395w-27a(h),” after “1395w-27(f)(2),”.

2002—Subsec. (e)(2)(A). Pub. L. 107-188, § 532(a)(1), substituted “through 2004” for “through 2001” in heading and “during the period beginning January 1, 1998, and ending on December 31, 2004” for “during 1998, 1999, 2000, and 2001” in text.

Subsec. (e)(2)(B). Pub. L. 107-188, § 532(a)(2), substituted “during 2005” for “during 2002” in heading.

Subsec. (e)(2)(B)(i), (C)(i). Pub. L. 107-188, § 532(a)(3), substituted “2005” for “2002” wherever appearing.

Subsec. (e)(2)(D). Pub. L. 107-188, § 532(a)(4), substituted “2004” for “2001”.

Subsec. (e)(3)(B). Pub. L. 107-188, § 532(c)(1)(A), substituted “means, with respect to a year before 2003 and after 2005, the month of November before such year and with respect to 2003, 2004, and 2005, the period beginning on November 15 and ending on December 31 of the year before such year” for “means, with respect to a calendar year (beginning with 2000), the month of November before such year”.

Subsec. (e)(4). Pub. L. 107-188, § 532(a)(5), substituted “2005” for “2002” in introductory and concluding provisions.

Subsec. (e)(6)(A). Pub. L. 107-188, § 532(c)(1)(B), substituted “during the annual, coordinated election period under paragraph (3) for each subsequent year” for “each subsequent year (as provided in paragraph (3))”.

2000—Subsec. (a)(3)(B). Pub. L. 106-554, § 1(a)(6) [title VI, § 620(a)], substituted “except that—” and cls. (i) and (ii) for “except that an individual who develops end-stage renal disease while enrolled in a Medicare+Choice plan may continue to be enrolled in that plan.”

Subsec. (d)(4)(B). Pub. L. 106-554, § 1(a)(6) [title VI, § 606(a)(2)(C)], designated existing provisions as cl. (i), inserted heading, and added cl. (ii).

Subsec. (f)(2). Pub. L. 106-554, § 1(a)(6) [title VI, § 619(a)], struck out “, except that if such election or change is made after the 10th day of any calendar month, then the election or change shall not take effect until the first day of the second calendar month following the date on which the election or change is made” before period at end.

Subsec. (h)(1)(A). Pub. L. 106-554, § 1(a)(6) [title VI, § 613(a)(1)], inserted “(or 10 days in the case described in paragraph (5))” after “45 days”.

Subsec. (h)(5). Pub. L. 106-554, § 1(a)(6) [title VI, § 613(a)(2)], added par. (5).

1999—Subsec. (b)(1)(A). Pub. L. 106-113, § 1000(a)(6) [title V, § 501(c)(1)], inserted “and except as provided in subparagraph (C)” after “may otherwise provide”.

Subsec. (b)(1)(C). Pub. L. 106-113, § 1000(a)(6) [title V, § 501(c)(2)], added subpar. (C).

Subsec. (e)(2)(B)(i). Pub. L. 106-113, § 1000(a)(6) [title V, § 501(b)(1)], inserted “and subparagraph (D)” after “clause (ii)”.

Subsec. (e)(2)(C)(i). Pub. L. 106-113, § 1000(a)(6) [title V, § 501(b)(2)], inserted “and subparagraph (D)” after “clause (ii)”.

Subsec. (e)(2)(D). Pub. L. 106-113, § 1000(a)(6) [title V, § 501(b)(3)], added subpar. (D).

Subsec. (e)(3)(C). Pub. L. 106-113, § 1000(a)(6) [title V, § 519(a)], substituted “During the fall season” for “In the month of November”.

Subsec. (e)(4)(A). Pub. L. 106-113, §1000(a)(6) [title V, §501(a)(1)], added subpar. (A) and struck out former subpar. (A) which read as follows: “the organization’s or plan’s certification under this part has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;”.

Subsec. (f)(2). Pub. L. 106-113, §1000(a)(6) [title V, §502(a)], inserted “or change” before “is made” and “, except that if such election or change is made after the 10th day of any calendar month, then the election or change shall not take effect until the first day of the second calendar month following the date on which the election or change is made” before the period at end.

Subsec. (i)(2). Pub. L. 106-113, §1000(a)(6) [title III, §321(k)(6)(A)], struck out “and” after “1395w-27(f)(2),”.

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111-152, title I, §1102(a), Mar. 30, 2010, 124 Stat. 1040, provided that sections 3201 (amending this section and sections 1395w-23, 1395w-24, 1395w-27a, 1395w-29, and 1395eee of this title and enacting provisions set out as notes under this section and section 1395w-24 of this title) and 3203 (amending section 1395w-23 of this title) of Pub. L. 111-148, and the amendments made by such sections, were repealed, effective as if included in the enactment of Pub. L. 111-148.

Pub. L. 111-148, title III, §3201(e)(2)(B), Mar. 23, 2010, 124 Stat. 447, which provided that amendments by section 3201(e)(2) of Pub. L. 111-148 (amending this section and sections 1395w-23 and 1395w-24 of this title) would take effect on Jan. 1, 2012, was repealed by Pub. L. 111-152, title I, §1102(a), Mar. 30, 2010, 124 Stat. 1040, effective as if included in the enactment of Pub. L. 111-148.

Pub. L. 111-148, title III, §3204(a)(2), Mar. 23, 2010, 124 Stat. 456, provided that: “The amendment made by paragraph (1) [amending this section] shall apply with respect to 2011 and succeeding years.”

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110-275, title I, §103(a)(3), July 15, 2008, 122 Stat. 2499, provided that: “The amendments made by this subsection [amending this section and section 1395w-104 of this title] shall apply to plan years beginning on or after January 1, 2009.”

Pub. L. 110-275, title I, §103(b)(3), July 15, 2008, 122 Stat. 2500, provided that: “The amendments made by this subsection [amending this section and section 1395w-104 of this title] shall take effect on a date specified by the Secretary (but in no case later than November 15, 2008).”

Pub. L. 110-275, title I, §103(d)(3), July 15, 2008, 122 Stat. 2501, provided that: “The amendments made by this subsection [amending this section and section 1395w-104 of this title] shall apply to plan years beginning on or after January 1, 2009.”

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108-173, title I, §102(c)(2), Dec. 8, 2003, 117 Stat. 2154, provided that: “The amendments made by this subsection [amending this section] shall apply on and after January 1, 2006.”

Pub. L. 108-173, title II, §223(a), Dec. 8, 2003, 117 Stat. 2207, provided that: “The amendments made by this subtitle [subtitle C (§§221-223) of title II of Pub. L. 108-173, enacting section 1395w-27a of this title and amending this section and sections 1395r, 1395s, 1395w, 1395w-22 to 1395w-24, 1395w-27, and 1395w-28 of this title] shall apply with respect to plan years beginning on or after January 1, 2006.”

Pub. L. 108-173, title II, §231(f)(1), Dec. 8, 2003, 117 Stat. 2208, provided that: “The amendments made by subsections (a), (b), and (c) [amending this section and section 1395w-28 of this title] shall take effect upon the date of the enactment of this Act [Dec. 8, 2003].”

Amendment by section 237(b)(2)(A) of Pub. L. 108-173 applicable to services provided on or after Jan. 1, 2006, and contract years beginning on or after such date, see

section 237(e) of Pub. L. 108-173, set out as a note under section 1320a-7b of this title.

EFFECTIVE DATE OF 2002 AMENDMENT

Pub. L. 107-188, title V, §532(c)(2), June 12, 2002, 116 Stat. 696, provided that: “The amendment made by paragraph (1) [amending this section] shall apply to the annual, coordinated election period for years beginning with 2003.”

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by section 1(a)(6) [title VI, §606(a)(2)(C)] of Pub. L. 106-554 applicable to years beginning with 2003, see section 1(a)(6) [title VI, §606(b)] of Pub. L. 106-554, set out as a note under section 1395r of this title.

Pub. L. 106-554, §1(a)(6) [title VI, §613(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-560, provided that: “The amendments made by subsection (a) [amending this section] shall apply to marketing material submitted on or after January 1, 2001.”

Pub. L. 106-554, §1(a)(6) [title VI, §619(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-563, provided that: “The amendment made by this section [amending this section] shall apply to elections and changes of coverage made on or after June 1, 2001.”

Pub. L. 106-554, §1(a)(6) [title VI, §620(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-564, provided that:

“(1) IN GENERAL.—The amendment made by subsection (a) [amending this section] shall apply to terminations and discontinuations occurring on or after the date of the enactment of this Act [Dec. 21, 2000].

“(2) APPLICATION TO PRIOR PLAN TERMINATIONS.—Clause (ii) of section 1851(a)(3)(B) of the Social Security Act [42 U.S.C. 1395w-21(a)(3)(B)(ii)] (as inserted by subsection (a)) shall also apply to individuals whose enrollment in a Medicare+Choice plan was terminated or discontinued after December 31, 1998, and before the date of the enactment of this Act. In applying this paragraph, such an individual shall be treated, for purposes of part C of title XVIII of the Social Security Act [42 U.S.C. 1395w-21 et seq.], as having discontinued enrollment in such a plan as of the date of the enactment of this Act.”

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 1000(a)(6) [title III, §321(k)(6)(A)] of Pub. L. 106-113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105-33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106-113, set out as a note under section 1395d of this title.

Pub. L. 106-113, div. B, §1000(a)(6) [title V, §501(d)], Nov. 29, 1999, 113 Stat. 1536, 1501A-379, provided that:

“(1) The amendments made by subsection (a) [amending this section and section 1395ss of this title] apply to notices of impending terminations or discontinuances made on or after the date of the enactment of this Act [Nov. 29, 1999].

“(2) The amendments made by subsection (c) [amending this section] apply to elections made on or after the date of the enactment of this Act [Nov. 29, 1999] with respect to eliminations of Medicare+Choice payment areas from a service area that occur before, on, or after the date of the enactment of this Act.”

Pub. L. 106-113, div. B, §1000(a)(6) [title V, §502(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A-380, provided that: “The amendments made by this section [amending this section] apply to elections and changes of coverage made on or after January 1, 2000.”

Pub. L. 106-113, div. B, §1000(a)(6) [title V, §519(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A-385, provided that: “The amendment made by subsection (a) [amending this section] first applies to campaigns conducted beginning in 2000.”

REGULATIONS

Pub. L. 108-173, title II, §223(b), Dec. 8, 2003, 117 Stat. 2207, provided that: “The Secretary [of Health and

Human Services] shall revise the regulations previously promulgated to carry out part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] to carry out the provisions of this Act [see Tables for classification].”

CONSTRUCTION

Pub. L. 108–173, title II, § 221(b)(2), Dec. 8, 2003, 117 Stat. 2181, provided that: “Nothing in part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] shall be construed as preventing an MSA plan or MA private fee-for-service plan from having a service area that covers one or more MA regions or the entire nation.”

NO CUTS IN GUARANTEED BENEFITS.

Pub. L. 111–148, title III, § 3602, Mar. 23, 2010, 124 Stat. 538, provided that: “Nothing in this Act [see Short Title note set out under section 18001 of this title] shall result in the reduction or elimination of any benefits guaranteed by law to participants in Medicare Advantage plans.”

IMPLEMENTATION OF MEDICARE ADVANTAGE PROGRAM

Pub. L. 108–173, title II, § 201, Dec. 8, 2003, 117 Stat. 2176, provided that:

“(a) IN GENERAL.—There is hereby established the Medicare Advantage program. The Medicare Advantage program shall consist of the program under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] (as amended by this Act [see Tables for classification]).

“(b) REFERENCES.—Subject to subsection (c), any reference to the program under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] shall be deemed a reference to the Medicare Advantage program and, with respect to such part, any reference to ‘Medicare+Choice’ is deemed a reference to ‘Medicare Advantage’ and ‘MA’.

“(c) TRANSITION.—In order to provide for an orderly transition and avoid beneficiary and provider confusion, the Secretary [of Health and Human Services] shall provide for an appropriate transition in the use of the terms ‘Medicare+Choice’ and ‘Medicare Advantage’ (or ‘MA’) in reference to the program under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.]. Such transition shall be fully completed for all materials for plan years beginning not later than January 1, 2006. Before the completion of such transition, any reference to ‘Medicare Advantage’ or ‘MA’ shall be deemed to include a reference to ‘Medicare+Choice’.”

REPORT ON IMPACT OF INCREASED FINANCIAL ASSISTANCE TO MEDICARE ADVANTAGE PLANS

Pub. L. 108–173, title II, § 211(g), Dec. 8, 2003, 117 Stat. 2178, directed the Secretary of Health and Human Services to submit to Congress, not later than July 1, 2006, a report that described the impact of additional financing provided under Pub. L. 108–173 and other Acts on the availability of Medicare Advantage plans in different areas and its impact on lowering premiums and increasing benefits under such plans.

MEDPAC STUDY AND REPORT ON CLARIFICATION OF AUTHORITY REGARDING DISAPPROVAL OF UNREASONABLE BENEFICIARY COST-SHARING

Pub. L. 108–173, title II, § 211(h), Dec. 8, 2003, 117 Stat. 2179, directed the Medicare Payment Advisory Commission, in consultation with beneficiaries, consumer groups, employers, and organizations offering plans under this part, to conduct a study to determine the extent to which the cost-sharing structures under such plans affect access to covered services or select enrollees based on the health status of eligible individuals described in subsection (a)(3) of this section, and to submit a report to Congress on such study not later than Dec. 31, 2004.

MORATORIUM ON NEW LOCAL PREFERRED PROVIDER ORGANIZATION PLANS

Pub. L. 108–173, title II, § 221(a)(2), Dec. 8, 2003, 117 Stat. 2180, directed the Secretary of Health and Human Services not to permit the offering of a local preferred provider organization plan under this part during 2006 or 2007 in a service area unless such plan was offered under this part (including under a demonstration project under this part) in such area as of Dec. 31, 2005.

SPECIALIZED MA PLANS

Pub. L. 110–275, title I, § 164(b), July 15, 2008, 122 Stat. 2571, provided that: “During the period beginning on January 1, 2010, and ending on December 31, 2010, the Secretary of Health and Human Services may not exercise the authority provided under section 231(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [Pub. L. 108–173] (42 U.S.C. 1395w–21 note) to designate other plans as specialized MA plans for special needs individuals.”

Pub. L. 110–173, title I, § 108(b), Dec. 29, 2007, 121 Stat. 2496, provided that:

“(1) AUTHORITY TO DESIGNATE OTHER PLANS AS SPECIALIZED MA PLANS.—During the period beginning on January 1, 2008, and ending on December 31, 2009, the Secretary of Health and Human Services shall not exercise the authority provided under section 231(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [Pub. L. 108–173] (42 U.S.C. 1395w–21 note) to designate other plans as specialized MA plans for special needs individuals under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.]. The preceding sentence shall not apply to plans designated as specialized MA plans for special needs individuals under such authority prior to January 1, 2008.

“(2) ENROLLMENT IN NEW PLANS.—During the period beginning on January 1, 2008, and ending on December 31, 2009, the Secretary of Health and Human Services shall not permit enrollment of any individual residing in an area in a specialized Medicare Advantage plan for special needs individuals under part C of title XVIII of the Social Security Act to take effect unless that specialized Medicare Advantage plan for special needs individuals was available for enrollment for individuals residing in that area on January 1, 2008.”

Pub. L. 108–173, title II, § 231(d), Dec. 8, 2003, 117 Stat. 2208, provided that: “In promulgating regulations to carry out section 1851(a)(2)(A)(ii) of the Social Security Act [42 U.S.C. 1395w–21(a)(2)(A)(ii)] (as added by subsection (a)) and section 1859(b)(6) of such Act [42 U.S.C. 1395w–28(b)(6)] (as added by subsection (b)), the Secretary [of Health and Human Services] may provide (notwithstanding section 1859(b)(6)(A) of such Act) for the offering of specialized MA plans for special needs individuals by MA plans that disproportionately serve special needs individuals.”

Pub. L. 108–173, title II, § 231(e), Dec. 8, 2003, 117 Stat. 2208, provided that: “Not later than December 31, 2007, the Secretary [of Health and Human Services] shall submit to Congress a report that assesses the impact of specialized MA plans for special needs individuals on the cost and quality of services provided to enrollees. Such report shall include an assessment of the costs and savings to the Medicare program as a result of amendments made by subsections (a), (b), and (c) [amending this section and section 1395w–28 of this title].”

MEDPAC STUDY ON CONSUMER COALITIONS

Pub. L. 106–554, § 1(a)(6) [title I, § 124], Dec. 21, 2000, 114 Stat. 2763, 2763A–478, directed the Medicare Payment Advisory Commission to conduct a study examining the use of consumer coalitions in the marketing of Medicare+Choice plans under the Medicare program under this subchapter and to submit a report on the study to Congress no later than 1 year after Dec. 21, 2000.

REPORT ON ACCOUNTING FOR VA AND DOD
EXPENDITURES FOR MEDICARE BENEFICIARIES

Pub. L. 106-113, div. B, §1000(a)(6) [title V, §551], Nov. 29, 1999, 113 Stat. 1536, 1501A-392, directed the Secretary of Health and Human Services, jointly with the Secretaries of Defense and of Veterans Affairs, to submit to Congress, no later than Apr. 1, 2001, a report on the estimated use of health care services furnished by the Departments of Defense and of Veterans Affairs to medicare beneficiaries.

REPORT ON MEDICARE MSA (MEDICAL SAVINGS
ACCOUNT) PLANS

Pub. L. 106-113, div. B, §1000(a)(6) [title V, §552(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A-393, directed the Medicare Payment Assessment Commission to submit to Congress, no later than 1 year after Nov. 29, 1999, a report on specific legislative changes that should be made to make MSA plans a viable option under the Medicare+Choice program.

GAO AUDIT AND REPORTS ON PROVISION OF
MEDICARE+CHOICE HEALTH INFORMATION TO BENE-
FIICIARIES

Pub. L. 106-113, div. B, §1000(a)(6) [title V, §553(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A-393, provided that:

“(1) IN GENERAL.—Beginning in 2000, the Comptroller General shall conduct an annual audit of the expenditures by the Secretary of Health and Human Services during the preceding year in providing information regarding the Medicare+Choice program under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w-21 et seq.) to eligible medicare beneficiaries.

“(3) [2] REPORTS.—Not later than March 31 of 2001, 2004, 2007, and 2010, the Comptroller General shall submit a report to Congress on the results of the audit of the expenditures of the preceding 3 years conducted pursuant to subsection (a) [enacting provisions set out as a note under section 1395ss of this title], together with an evaluation of the effectiveness of the means used by the Secretary of Health and Human Services in providing information regarding the Medicare+Choice program under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w-21 et seq.) to eligible medicare beneficiaries.”

ENROLLMENT TRANSITION RULE

Pub. L. 105-33, title IV, §4002(c), Aug. 5, 1997, 111 Stat. 329, provided that: “An individual who is enrolled on December 31, 1998, with an eligible organization under section 1876 of the Social Security Act (42 U.S.C. 1395mm) shall be considered to be enrolled with that organization on January 1, 1999, under part C of title XVIII of such Act [42 U.S.C. 1395w-21 et seq.] if that organization has a contract under that part for providing services on January 1, 1999 (unless the individual has disenrolled effective on that date).”

SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL

Pub. L. 105-33, title IV, §4002(f)(2), Aug. 5, 1997, 111 Stat. 330, directed the Secretary of Health and Human Services to submit to Congress, no later than 6 months after Aug. 5, 1997, proposed technical and conforming amendments in the law as required by the provisions of chapter 1 (§§4001-4006) of subtitle A of title IV of Pub. L. 105-33.

REPORT ON INTEGRATION AND TRANSITION

Pub. L. 105-33, title IV, §4014(c), Aug. 5, 1997, 111 Stat. 337, directed the Secretary of Health and Human Services to submit to Congress, no later than Jan. 1, 1999, a plan which provided for the integration of health plans offered by social health maintenance organizations and similar plans as an option under the Medicare+Choice program under this part, for a transition for such organizations operating under demonstration project authority, and for appropriate payment levels for plans offered by such organizations.

MEDICARE ENROLLMENT DEMONSTRATION PROJECT

Pub. L. 105-33, title IV, §4018, Aug. 5, 1997, 111 Stat. 346, provided that:

“(a) DEMONSTRATION PROJECT.—

“(1) ESTABLISHMENT.—The Secretary shall implement a demonstration project (in this section referred to as the ‘project’) for the purpose of evaluating the use of a third-party contractor to conduct the Medicare+Choice plan enrollment and disenrollment functions, as described in part C of title XVIII of the Social Security Act [42 U.S.C. 1395w-21 et seq.] (as added by section 4001 of this Act), in an area.

“(2) CONSULTATION.—Before implementing the project under this section, the Secretary shall consult with affected parties on—

“(A) the design of the project;

“(B) the selection criteria for the third-party contractor; and

“(C) the establishment of performance standards, as described in paragraph (3).

“(3) PERFORMANCE STANDARDS.—

“(A) IN GENERAL.—The Secretary shall establish performance standards for the accuracy and timeliness of the Medicare+Choice plan enrollment and disenrollment functions performed by the third-party contractor.

“(B) NONCOMPLIANCE.—In the event that the third-party contractor is not in substantial compliance with the performance standards established under subparagraph (A), such enrollment and disenrollment functions shall be performed by the Medicare+Choice plan until the Secretary appoints a new third-party contractor.

“(b) REPORT TO CONGRESS.—The Secretary shall periodically report to Congress on the progress of the project conducted pursuant to this section.

“(c) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of part C of title XVIII of the Social Security Act [42 U.S.C. 1395w-21 et seq.] (as amended by section 4001 of this Act) to such extent and for such period as the Secretary determines is necessary to conduct the project.

“(d) DURATION.—A demonstration project under this section shall be conducted for a 3-year period.

“(e) SEPARATE FROM OTHER DEMONSTRATION PROJECTS.—A project implemented by the Secretary under this section shall not be conducted in conjunction with any other demonstration project.”

§ 1395w-22. Benefits and beneficiary protections

(a) Basic benefits

(1) Requirement

(A) In general

Except as provided in section 1395w-28(b)(3) of this title for MSA plans and except as provided in paragraph (6) for MA regional plans, each Medicare+Choice plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this subchapter and part A of subchapter XI of this chapter, benefits under the original medicare fee-for-service program option (and, for plan years before 2006, additional benefits required under section 1395w-24(f)(1)(A) of this title).

(B) Benefits under the original medicare fee-for-service program option defined

(i) In general

For purposes of this part, the term “benefits under the original medicare fee-for-service program option” means those items and services (other than hospice care) for which benefits are available under parts A and B to individuals entitled

to benefits under part A and enrolled under part B, with cost-sharing for those services as required under parts A and B or, subject to clause (iii), an actuarially equivalent level of cost-sharing as determined in this part.

(ii) Special rule for regional plans

In the case of an MA regional plan in determining an actuarially equivalent level of cost-sharing with respect to benefits under the original medicare fee-for-service program option, there shall only be taken into account, with respect to the application of section 1395w-27a(b)(2) of this title, such expenses only with respect to subparagraph (A) of such section.

(iii) Limitation on variation of cost sharing for certain benefits

Subject to clause (v), cost-sharing for services described in clause (iv) shall not exceed the cost-sharing required for those services under parts A and B.

(iv) Services described

The following services are described in this clause:

- (I) Chemotherapy administration services.
- (II) Renal dialysis services (as defined in section 1395rr(b)(14)(B) of this title).
- (III) Skilled nursing care.
- (IV) Such other services that the Secretary determines appropriate (including services that the Secretary determines require a high level of predictability and transparency for beneficiaries).

(v) Exception

In the case of services described in clause (iv) for which there is no cost-sharing required under parts A and B, cost-sharing may be required for those services in accordance with clause (i).

(2) Satisfaction of requirement

(A) In general

A Medicare+Choice plan (other than an MSA plan) offered by a Medicare+Choice organization satisfies paragraph (1)(A), with respect to benefits for items and services furnished other than through a provider or other person that has a contract with the organization offering the plan, if the plan provides payment in an amount so that—

- (i) the sum of such payment amount and any cost sharing provided for under the plan, is equal to at least
- (ii) the total dollar amount of payment for such items and services as would otherwise be authorized under parts A and B of this subchapter (including any balance billing permitted under such parts).

(B) Reference to related provisions

For provision relating to—

- (i) limitations on balance billing against Medicare+Choice organizations for non-contract providers, see subsection (k) of this section and section 1395cc(a)(1)(O) of this title, and
- (ii) limiting actuarial value of enrollee liability for covered benefits, see section 1395w-24(e) of this title.

(C) Election of uniform coverage determination

In the case of a Medicare+Choice organization that offers a Medicare+Choice plan in an area in which more than one local coverage determination is applied with respect to different parts of the area, the organization may elect to have the local coverage determination for the part of the area that is most beneficial to Medicare+Choice enrollees (as identified by the Secretary) apply with respect to all Medicare+Choice enrollees enrolled in the plan.

(3) Supplemental benefits

(A) Benefits included subject to Secretary's approval

Each Medicare+Choice organization may provide to individuals enrolled under this part, other than under an MSA plan (without affording those individuals an option to decline the coverage), supplemental health care benefits that the Secretary may approve. The Secretary shall approve any such supplemental benefits unless the Secretary determines that including such supplemental benefits would substantially discourage enrollment by Medicare+Choice eligible individuals with the organization.

(B) At enrollees' option

(i) In general

Subject to clause (ii), a Medicare+Choice organization may provide to individuals enrolled under this part supplemental health care benefits that the individuals may elect, at their option, to have covered.

(ii) Special rule for MSA plans

A Medicare+Choice organization may not provide, under an MSA plan, supplemental health care benefits that cover the deductible described in section 1395w-28(b)(2)(B) of this title. In applying the previous sentence, health benefits described in section 1395ss(u)(2)(B) of this title shall not be treated as covering such deductible.

(C) Application to Medicare+Choice private fee-for-service plans

Nothing in this paragraph shall be construed as preventing a Medicare+Choice private fee-for-service plan from offering supplemental benefits that include payment for some or all of the balance billing amounts permitted consistent with subsection (k) of this section and coverage of additional services that the plan finds to be medically necessary. Such benefits may include reductions in cost-sharing below the actuarial value specified in section 1395w-24(e)(4)(B) of this title.

(4) Organization as secondary payer

Notwithstanding any other provision of law, a Medicare+Choice organization may (in the case of the provision of items and services to an individual under a Medicare+Choice plan under circumstances in which payment under this subchapter is made secondary pursuant to

section 1395y(b)(2) of this title) charge or authorize the provider of such services to charge, in accordance with the charges allowed under a law, plan, or policy described in such section—

(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or

(B) such individual to the extent that the individual has been paid under such law, plan, or policy for such services.

(5) National coverage determinations and legislative changes in benefits

If there is a national coverage determination or legislative change in benefits required to be provided under this part made in the period beginning on the date of an announcement under section 1395w-23(b) of this title and ending on the date of the next announcement under such section and the Secretary projects that the determination will result in a significant change in the costs to a Medicare+Choice organization of providing the benefits that are the subject of such national coverage determination and that such change in costs was not incorporated in the determination of the annual Medicare+Choice capitation rate under section 1395w-23 of this title included in the announcement made at the beginning of such period, then, unless otherwise required by law—

(A) such determination or legislative change in benefits shall not apply to contracts under this part until the first contract year that begins after the end of such period, and

(B) if such coverage determination or legislative change provides for coverage of additional benefits or coverage under additional circumstances, section 1395w-21(i)(1) of this title shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period.

The projection under the previous sentence shall be based on an analysis by the Chief Actuary of the Centers for Medicare & Medicaid Services of the actuarial costs associated with the coverage determination or legislative change in benefits.

(6) Special benefit rules for regional plans

In the case of an MA plan that is an MA regional plan, benefits under the plan shall include the benefits described in paragraphs (1) and (2) of section 1395w-27a(b) of this title.

(7) Limitation on cost-sharing for dual eligibles and qualified medicare beneficiaries

In the case of an individual who is a full-benefit dual eligible individual (as defined in section 1396u-5(c)(6) of this title) or a qualified medicare beneficiary (as defined in section 1396d(p)(1) of this title) and who is enrolled in a specialized Medicare Advantage plan for special needs individuals described in section 1395w-28(b)(6)(B)(ii) of this title, the plan may not impose cost-sharing that exceeds the amount of cost-sharing that would be per-

mitted with respect to the individual under subchapter XIX if the individual were not enrolled in such plan.

(b) Antidiscrimination

(1) Beneficiaries

(A) In general

A Medicare+Choice organization may not deny, limit, or condition the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.¹ The Secretary shall not approve a plan of an organization if the Secretary determines that the design of the plan and its benefits are likely to substantially discourage enrollment by certain MA eligible individuals with the organization.

(B) Construction

Subparagraph (A) shall not be construed as requiring a Medicare+Choice organization to enroll individuals who are determined to have end-stage renal disease, except as provided under section 1395w-21(a)(3)(B) of this title.

(2) Providers

A Medicare+Choice organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan.

(c) Disclosure requirements

(1) Detailed description of plan provisions

A Medicare+Choice organization shall disclose, in clear, accurate, and standardized form to each enrollee with a Medicare+Choice plan offered by the organization under this part at the time of enrollment and at least annually thereafter, the following information regarding such plan:

(A) Service area

The plan's service area.

(B) Benefits

Benefits offered under the plan, including information described in section 1395w-21(d)(3)(A) of this title and exclusions from coverage and, if it is an MSA plan, a comparison of benefits under such a plan with benefits under other Medicare+Choice plans.

(C) Access

The number, mix, and distribution of plan providers, out-of-network coverage (if any) provided by the plan, and any point-of-serv-

¹ See References in Text note below.

ice option (including the supplemental premium for such option).

(D) Out-of-area coverage

Out-of-area coverage provided by the plan.

(E) Emergency coverage

Coverage of emergency services, including—

- (i) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;
- (ii) the process and procedures of the plan for obtaining emergency services; and
- (iii) the locations of (I) emergency departments, and (II) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

(F) Supplemental benefits

Supplemental benefits available from the organization offering the plan, including—

- (i) whether the supplemental benefits are optional,
- (ii) the supplemental benefits covered, and
- (iii) the Medicare+Choice monthly supplemental beneficiary premium for the supplemental benefits.

(G) Prior authorization rules

Rules regarding prior authorization or other review requirements that could result in nonpayment.

(H) Plan grievance and appeals procedures

All plan appeal or grievance rights and procedures.

(I) Quality improvement program

A description of the organization's quality improvement program under subsection (e) of this section.

(2) Disclosure upon request

Upon request of a Medicare+Choice eligible individual, a Medicare+Choice organization must provide the following information to such individual:

- (A) The general coverage information and general comparative plan information made available under clauses (i) and (ii) of section 1395w-21(d)(2)(A) of this title.
- (B) Information on procedures used by the organization to control utilization of services and expenditures.
- (C) Information on the number of grievances, redeterminations, and appeals and on the disposition in the aggregate of such matters.
- (D) An overall summary description as to the method of compensation of participating physicians.

(d) Access to services

(1) In general

A Medicare+Choice organization offering a Medicare+Choice plan may select the providers from whom the benefits under the plan are provided so long as—

(A) the organization makes such benefits available and accessible to each individual electing the plan within the plan service area with reasonable promptness and in a manner which assures continuity in the provision of benefits;

(B) when medically necessary the organization makes such benefits available and accessible 24 hours a day and 7 days a week;

(C) the plan provides for reimbursement with respect to services which are covered under subparagraphs (A) and (B) and which are provided to such an individual other than through the organization, if—

(i) the services were not emergency services (as defined in paragraph (3)), but (I) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition, and (II) it was not reasonable given the circumstances to obtain the services through the organization,

(ii) the services were renal dialysis services and were provided other than through the organization because the individual was temporarily out of the plan's service area, or

(iii) the services are maintenance care or post-stabilization care covered under the guidelines established under paragraph (2);

(D) the organization provides access to appropriate providers, including credentialed specialists, for medically necessary treatment and services; and

(E) coverage is provided for emergency services (as defined in paragraph (3)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization.

(2) Guidelines respecting coordination of post-stabilization care

A Medicare+Choice plan shall comply with such guidelines as the Secretary may prescribe relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after the enrollee has been determined to be stable under section 1395dd of this title.

(3) "Emergency services" defined

In this subsection—

(A) In general

The term "emergency services" means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

- (i) are furnished by a provider that is qualified to furnish such services under this subchapter, and
- (ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (B)).

(B) Emergency medical condition based on prudent layperson

The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowl-

edge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part.

(4) Assuring access to services in Medicare+Choice private fee-for-service plans

In addition to any other requirements under this part, in the case of a Medicare+Choice private fee-for-service plan, the organization offering the plan must demonstrate to the Secretary that the organization has sufficient number and range of health care professionals and providers willing to provide services under the terms of the plan. Subject to paragraphs (5) and (6), the Secretary shall find that an organization has met such requirement with respect to any category of health care professional or provider if, with respect to that category of provider—

(A) the plan has established payment rates for covered services furnished by that category of provider that are not less than the payment rates provided for under part A of this subchapter, part B of this subchapter, or both, for such services, or

(B) the plan has contracts or agreements (other than deemed contracts or agreements under subsection (j)(6) of this section) with a sufficient number and range of providers within such category to meet the access standards in subparagraphs (A) through (E) of paragraph (1),

or a combination of both. The previous sentence shall not be construed as restricting the persons from whom enrollees under such a plan may obtain covered benefits, except that, if a plan entirely meets such requirement with respect to a category of health care professional or provider on the basis of subparagraph (B), it may provide for a higher beneficiary copayment in the case of health care professionals and providers of that category who do not have contracts or agreements (other than deemed contracts or agreements under subsection (j)(6) of this section) to provide covered services under the terms of the plan.

(5) Requirement of certain nonemployer Medicare Advantage private fee-for-service plans to use contracts with providers

(A) In general

For plan year 2011 and subsequent plan years, in the case of a Medicare Advantage private fee-for-service plan not described in paragraph (1) or (2) of section 1395w-27(i) of this title operating in a network area (as defined in subparagraph (B)), the plan shall meet the access standards under paragraph (4) in that area only through entering into written contracts as provided for under subparagraph (B) of such paragraph and not, in whole or in part, through the establishment

of payment rates meeting the requirements under subparagraph (A) of such paragraph.

(B) Network area defined

For purposes of subparagraph (A), the term “network area” means, for a plan year, an area which the Secretary identifies (in the Secretary’s announcement of the proposed payment rates for the previous plan year under section 1395w-23(b)(1)(B) of this title) as having at least 2 network-based plans (as defined in subparagraph (C)) with enrollment under this part as of the first day of the year in which such announcement is made.

(C) Network-based plan defined

(i) In general

For purposes of subparagraph (B), the term “network-based plan” means—

(I) except as provided in clause (ii), a Medicare Advantage plan that is a coordinated care plan described in section 1395w-21(a)(2)(A)(i) of this title;

(II) a network-based MSA plan; and

(III) a reasonable cost reimbursement plan under section 1395mm of this title.

(ii) Exclusion of non-network regional PPOS

The term “network-based plan” shall not include an MA regional plan that, with respect to the area, meets access adequacy standards under this part substantially through the authority of section 422.112(a)(1)(ii) of title 42, Code of Federal Regulations, rather than through written contracts.

(6) Requirement of all employer Medicare Advantage private fee-for-service plans to use contracts with providers

For plan year 2011 and subsequent plan years, in the case of a Medicare Advantage private fee-for-service plan that is described in paragraph (1) or (2) of section 1395w-27(i) of this title, the plan shall meet the access standards under paragraph (4) only through entering into written contracts as provided for under subparagraph (B) of such paragraph and not, in whole or in part, through the establishment of payment rates meeting the requirements under subparagraph (A) of such paragraph.

(e) Quality improvement program

(1) In general

Each MA organization shall have an ongoing quality improvement program for the purpose of improving the quality of care provided to enrollees in each MA plan offered by such organization.

(2) Chronic care improvement programs

As part of the quality improvement program under paragraph (1), each MA organization shall have a chronic care improvement program. Each chronic care improvement program shall have a method for monitoring and identifying enrollees with multiple or sufficiently severe chronic conditions that meet criteria established by the organization for participation under the program.

(3) Data**(A) Collection, analysis, and reporting****(i) In general**

Except as provided in clauses (ii) and (iii) with respect to plans described in such clauses and subject to subparagraph (B), as part of the quality improvement program under paragraph (1), each MA organization shall provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality. With respect to MA private fee-for-service plans and MSA plans, the requirements under the preceding sentence may not exceed the requirements under this subparagraph with respect to MA local plans that are preferred provider organization plans, except that, for plan year 2010, the limitation under clause (iii) shall not apply and such requirements shall apply only with respect to administrative claims data.

(ii) Special requirements for specialized MA plans for special needs individuals

In addition to the data required to be collected, analyzed, and reported under clause (i) and notwithstanding the limitations under subparagraph (B), as part of the quality improvement program under paragraph (1), each MA organization offering a specialized Medicare Advantage plan for special needs individuals shall provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality with respect to the requirements described in paragraphs (2) through (5) of subsection (f). Such data may be based on claims data and shall be at the plan level.

(iii) Application to local preferred provider organizations and MA regional plans

Clause (i) shall apply to MA organizations with respect to MA local plans that are preferred provider organization plans and to MA regional plans only insofar as services are furnished by providers or services, physicians, and other health care practitioners and suppliers that have contracts with such organization to furnish services under such plans.

(iv) Definition of preferred provider organization plan

In this subparagraph, the term “preferred provider organization plan” means an MA plan that—

- (I) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;
- (II) provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and
- (III) is offered by an organization that is not licensed or organized under State law as a health maintenance organization.

(B) Limitations**(i) Types of data**

The Secretary shall not collect under subparagraph (A) data on quality, outcomes, and beneficiary satisfaction to facilitate consumer choice and program administration other than the types of data that were collected by the Secretary as of November 1, 2003.

(ii) Changes in types of data

Subject to subclause (iii), the Secretary may only change the types of data that are required to be submitted under subparagraph (A) after submitting to Congress a report on the reasons for such changes that was prepared in consultation with MA organizations and private accrediting bodies.

(iii) Construction

Nothing in the² subsection shall be construed as restricting the ability of the Secretary to carry out the duties under section 1395w-21(d)(4)(D) of this title.

(4) Treatment of accreditation**(A) In general**

The Secretary shall provide that a Medicare+Choice organization is deemed to meet all the requirements described in any specific clause of subparagraph (B) if the organization is accredited (and periodically re-accredited) by a private accrediting organization under a process that the Secretary has determined assures that the accrediting organization applies and enforces standards that meet or exceed the standards established under section 1395w-26 of this title to carry out the requirements in such clause.

(B) Requirements described

The provisions described in this subparagraph are the following:

- (i) Paragraphs (1) through (3) of this subsection (relating to quality improvement programs).
- (ii) Subsection (b) of this section (relating to antidiscrimination).
- (iii) Subsection (d) of this section (relating to access to services).
- (iv) Subsection (h) of this section (relating to confidentiality and accuracy of enrollee records).
- (v) Subsection (i) of this section (relating to information on advance directives).
- (vi) Subsection (j) of this section (relating to provider participation rules).
- (vii) The requirements described in section 1395w-104(j) of this title, to the extent such requirements apply under section 1395w-131(c) of this title.

(C) Timely action on applications

The Secretary shall determine, within 210 days after the date the Secretary receives an application by a private accrediting organization and using the criteria specified in section 1395bb(a)(2) of this title, whether the process of the private accrediting organiza-

² So in original. Probably should be “this”.

tion meets the requirements with respect to any specific clause in subparagraph (B) with respect to which the application is made. The Secretary may not deny such an application on the basis that it seeks to meet the requirements with respect to only one, or more than one, such specific clause.

(D) Construction

Nothing in this paragraph shall be construed as limiting the authority of the Secretary under section 1395w-27 of this title, including the authority to terminate contracts with Medicare+Choice organizations under subsection (c)(2) of such section.

(f) Grievance mechanism

Each Medicare+Choice organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and enrollees with Medicare+Choice plans of the organization under this part.

(g) Coverage determinations, reconsiderations, and appeals

(1) Determinations by organization

(A) In general

A Medicare+Choice organization shall have a procedure for making determinations regarding whether an individual enrolled with the plan of the organization under this part is entitled to receive a health service under this section and the amount (if any) that the individual is required to pay with respect to such service. Subject to paragraph (3), such procedures shall provide for such determination to be made on a timely basis.

(B) Explanation of determination

Such a determination that denies coverage, in whole or in part, shall be in writing and shall include a statement in understandable language of the reasons for the denial and a description of the reconsideration and appeals processes.

(2) Reconsiderations

(A) In general

The organization shall provide for reconsideration of a determination described in paragraph (1)(B) upon request by the enrollee involved. The reconsideration shall be within a time period specified by the Secretary, but shall be made, subject to paragraph (3), not later than 60 days after the date of the receipt of the request for reconsideration.

(B) Physician decision on certain reconsiderations

A reconsideration relating to a determination to deny coverage based on a lack of medical necessity shall be made only by a physician with appropriate expertise in the field of medicine which necessitates treatment who is other than a physician involved in the initial determination.

(3) Expedited determinations and reconsiderations

(A) Receipt of requests

(i) Enrollee requests

An enrollee in a Medicare+Choice plan may request, either in writing or orally, an expedited determination under paragraph (1) or an expedited reconsideration under paragraph (2) by the Medicare+Choice organization.

(ii) Physician requests

A physician, regardless whether the physician is affiliated with the organization or not, may request, either in writing or orally, such an expedited determination or reconsideration.

(B) Organization procedures

(i) In general

The Medicare+Choice organization shall maintain procedures for expediting organization determinations and reconsiderations when, upon request of an enrollee, the organization determines that the application of the normal time frame for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(ii) Expedition required for physician requests

In the case of a request for an expedited determination or reconsideration made under subparagraph (A)(ii), the organization shall expedite the determination or reconsideration if the request indicates that the application of the normal time frame for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(iii) Timely response

In cases described in clauses (i) and (ii), the organization shall notify the enrollee (and the physician involved, as appropriate) of the determination or reconsideration under time limitations established by the Secretary, but not later than 72 hours of the time of receipt of the request for the determination or reconsideration (or receipt of the information necessary to make the determination or reconsideration), or such longer period as the Secretary may permit in specified cases.

(4) Independent review of certain coverage denials

The Secretary shall contract with an independent, outside entity to review and resolve in a timely manner reconsiderations that affirm denial of coverage, in whole or in part. The provisions of section 1395ff(c)(5) of this title shall apply to independent outside entities under contract with the Secretary under this paragraph.

(5) Appeals

An enrollee with a Medicare+Choice plan of a Medicare+Choice organization under this

part who is dissatisfied by reason of the enrollee's failure to receive any health service to which the enrollee believes the enrollee is entitled and at no greater charge than the enrollee believes the enrollee is required to pay is entitled, if the amount in controversy is \$100 or more, to a hearing before the Secretary to the same extent as is provided in section 405(b) of this title, and in any such hearing the Secretary shall make the organization a party. If the amount in controversy is \$1,000 or more, the individual or organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 405(g) of this title, and both the individual and the organization shall be entitled to be parties to that judicial review. In applying subsections (b) and (g) of section 405 of this title as provided in this paragraph, and in applying section 405(l) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively. The provisions of section 1395ff(b)(1)(E)(iii) of this title shall apply with respect to dollar amounts specified in the first 2 sentences of this paragraph in the same manner as they apply to the dollar amounts specified in section 1395ff(b)(1)(E)(i) of this title.

(h) Confidentiality and accuracy of enrollee records

Insofar as a Medicare+Choice organization maintains medical records or other health information regarding enrollees under this part, the Medicare+Choice organization shall establish procedures—

- (1) to safeguard the privacy of any individually identifiable enrollee information;
- (2) to maintain such records and information in a manner that is accurate and timely; and
- (3) to assure timely access of enrollees to such records and information.

(i) Information on advance directives

Each Medicare+Choice organization shall meet the requirement of section 1395cc(f) of this title (relating to maintaining written policies and procedures respecting advance directives).

(j) Rules regarding provider participation

(1) Procedures

Insofar as a Medicare+Choice organization offers benefits under a Medicare+Choice plan through agreements with physicians, the organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under such a plan. Such procedures shall include—

- (A) providing notice of the rules regarding participation,
- (B) providing written notice of participation decisions that are adverse to physicians, and
- (C) providing a process within the organization for appealing such adverse decisions, including the presentation of information and views of the physician regarding such decision.

(2) Consultation in medical policies

A Medicare+Choice organization shall consult with physicians who have entered into participation agreements with the organization regarding the organization's medical policy, quality, and medical management procedures.

(3) Prohibiting interference with provider advice to enrollees

(A) In general

Subject to subparagraphs (B) and (C), a Medicare+Choice organization (in relation to an individual enrolled under a Medicare+Choice plan offered by the organization under this part) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice.

(B) Conscience protection

Subparagraph (A) shall not be construed as requiring a Medicare+Choice plan to provide, reimburse for, or provide coverage of a counseling or referral service if the Medicare+Choice organization offering the plan—

- (i) objects to the provision of such service on moral or religious grounds; and
- (ii) in the manner and through the written instrumentalities such Medicare+Choice organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization or plan adopts a change in policy regarding such a counseling or referral service.

(C) Construction

Nothing in subparagraph (B) shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1001 et seq.].

(D) "Health care professional" defined

For purposes of this paragraph, the term "health care professional" means a physician (as defined in section 1395x(r) of this title) or other health care professional if coverage for the professional's services is provided under the Medicare+Choice plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

(4) Limitations on physician incentive plans**(A) In general**

No Medicare+Choice organization may operate any physician incentive plan (as defined in subparagraph (B)) unless the organization provides assurances satisfactory to the Secretary that the following requirements are met:

(i) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

(ii) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the organization provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or group.

(B) “Physician incentive plan” defined

In this paragraph, the term “physician incentive plan” means any compensation arrangement between a Medicare+Choice organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization under this part.

(5) Limitation on provider indemnification

A Medicare+Choice organization may not provide (directly or indirectly) for a health care professional, provider of services, or other entity providing health care services (or group of such professionals, providers, or entities) to indemnify the organization against any liability resulting from a civil action brought for any damage caused to an enrollee with a Medicare+Choice plan of the organization under this part by the organization’s denial of medically necessary care.

(6) Special rules for Medicare+Choice private fee-for-service plans

For purposes of applying this part (including subsection (k)(1) of this section) and section 1395cc(a)(1)(O) of this title, a hospital (or other provider of services), a physician or other health care professional, or other entity furnishing health care services is treated as having an agreement or contract in effect with a Medicare+Choice organization (with respect to an individual enrolled in a Medicare+Choice private fee-for-service plan it offers), if—

(A) the provider, professional, or other entity furnishes services that are covered under the plan to such an enrollee; and

(B) before providing such services, the provider, professional, or other entity—

(i) has been informed of the individual’s enrollment under the plan, and

(ii) either—

(I) has been informed of the terms and conditions of payment for such services under the plan, or

(II) is given a reasonable opportunity to obtain information concerning such terms and conditions,

in a manner reasonably designed to effect informed agreement by a provider.

The previous sentence shall only apply in the absence of an explicit agreement between such a provider, professional, or other entity and the Medicare+Choice organization.

(7) Promotion of e-prescribing by MA plans**(A) In general**

An MA-PD plan may provide for a separate payment or otherwise provide for a differential payment for a participating physician that prescribes covered part D drugs in accordance with an electronic prescription drug program that meets standards established under section 1395w-104(e) of this title.

(B) Considerations

Such payment may take into consideration the costs of the physician in implementing such a program and may also be increased for those participating physicians who significantly increase—

(i) formulary compliance;

(ii) lower cost, therapeutically equivalent alternatives;

(iii) reductions in adverse drug interactions; and

(iv) efficiencies in filing prescriptions through reduced administrative costs.

(C) Structure

Additional or increased payments under this subsection may be structured in the same manner as medication therapy management fees are structured under section 1395w-104(c)(2)(E)¹ of this title.

(k) Treatment of services furnished by certain providers**(1) In general**

Except as provided in paragraph (2), a physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this part with a Medicare+Choice organization described in section 1395w-21(a)(2)(A) of this title or with an organization offering an MSA plan shall accept as payment in full for covered services under this subchapter that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other provision of law that applies to such a payment with respect to an individual entitled to benefits under this subchapter (but not enrolled with a Medicare+Choice organization under this part) also applies with respect to an individual so enrolled.

(2) Application to Medicare+Choice private fee-for-service plans

(A) Balance billing limits under Medicare+Choice private fee-for-service plans in case of contract providers

(i) In general

In the case of an individual enrolled in a Medicare+Choice private fee-for-service plan under this part, a physician, provider of services, or other entity that has a contract (including through the operation of subsection (j)(6) of this section) establishing a payment rate for services furnished to the enrollee shall accept as payment in full for covered services under this subchapter that are furnished to such an individual an amount not to exceed (including any deductibles, coinsurance, copayments, or balance billing otherwise permitted under the plan) an amount equal to 115 percent of such payment rate.

(ii) Procedures to enforce limits

The Medicare+Choice organization that offers such a plan shall establish procedures, similar to the procedures described in section 1395w-4(g)(1)(A) of this title, in order to carry out the previous sentence.

(iii) Assuring enforcement

If the Medicare+Choice organization fails to establish and enforce procedures required under clause (ii), the organization is subject to intermediate sanctions under section 1395w-27(g) of this title.

(B) Enrollee liability for noncontract providers

For provision—

(i) establishing minimum payment rate in the case of noncontract providers under a Medicare+Choice private fee-for-service plan, see subsection (a)(2) of this section; or

(ii) limiting enrollee liability in the case of covered services furnished by such providers, see paragraph (1) and section 1395cc(a)(1)(O) of this title.

(C) Information on beneficiary liability

(i) In general

Each Medicare+Choice organization that offers a Medicare+Choice private fee-for-service plan shall provide that enrollees under the plan who are furnished services for which payment is sought under the plan are provided an appropriate explanation of benefits (consistent with that provided under parts A and B of this subchapter and, if applicable, under medicare supplemental policies) that includes a clear statement of the amount of the enrollee's liability (including any liability for balance billing consistent with this subsection) with respect to payments for such services.

(ii) Advance notice before receipt of inpatient hospital services and certain other services

In addition, such organization shall, in its terms and conditions of payments to

hospitals for inpatient hospital services and for other services identified by the Secretary for which the amount of the balance billing under subparagraph (A) could be substantial, require the hospital to provide to the enrollee, before furnishing such services and if the hospital imposes balance billing under subparagraph (A)—

(I) notice of the fact that balance billing is permitted under such subparagraph for such services, and

(II) a good faith estimate of the likely amount of such balance billing (if any), with respect to such services, based upon the presenting condition of the enrollee.

(I) Return to home skilled nursing facilities for covered post-hospital extended care services

(1) Ensuring return to home SNF

(A) In general

In providing coverage of post-hospital extended care services, a Medicare+Choice plan shall provide for such coverage through a home skilled nursing facility if the following conditions are met:

(i) Enrollee election

The enrollee elects to receive such coverage through such facility.

(ii) SNF agreement

The facility has a contract with the Medicare+Choice organization for the provision of such services, or the facility agrees to accept substantially similar payment under the same terms and conditions that apply to similarly situated skilled nursing facilities that are under contract with the Medicare+Choice organization for the provision of such services and through which the enrollee would otherwise receive such services.

(B) Manner of payment to home SNF

The organization shall provide payment to the home skilled nursing facility consistent with the contract or the agreement described in subparagraph (A)(ii), as the case may be.

(2) No less favorable coverage

The coverage provided under paragraph (1) (including scope of services, cost-sharing, and other criteria of coverage) shall be no less favorable to the enrollee than the coverage that would be provided to the enrollee with respect to a skilled nursing facility the post-hospital extended care services of which are otherwise covered under the Medicare+Choice plan.

(3) Rule of construction

Nothing in this subsection shall be construed to do the following:

(A) To require coverage through a skilled nursing facility that is not otherwise qualified to provide benefits under part A of this subchapter for medicare beneficiaries not enrolled in a Medicare+Choice plan.

(B) To prevent a skilled nursing facility from refusing to accept, or imposing conditions upon the acceptance of, an enrollee for the receipt of post-hospital extended care services.

(4) Definitions

In this subsection:

(A) Home skilled nursing facility

The term “home skilled nursing facility” means, with respect to an enrollee who is entitled to receive post-hospital extended care services under a Medicare+Choice plan, any of the following skilled nursing facilities:

(i) SNF residence at time of admission

The skilled nursing facility in which the enrollee resided at the time of admission to the hospital preceding the receipt of such post-hospital extended care services.

(ii) SNF in continuing care retirement community

A skilled nursing facility that is providing such services through a continuing care retirement community (as defined in subparagraph (B)) which provided residence to the enrollee at the time of such admission.

(iii) SNF residence of spouse at time of discharge

The skilled nursing facility in which the spouse of the enrollee is residing at the time of discharge from such hospital.

(B) Continuing care retirement community

The term “continuing care retirement community” means, with respect to an enrollee in a Medicare+Choice plan, an arrangement under which housing and health-related services are provided (or arranged) through an organization for the enrollee under an agreement that is effective for the life of the enrollee or for a specified period.

(Aug. 14, 1935, ch. 531, title XVIII, § 1852, as added Pub. L. 105-33, title IV, § 4001, Aug. 5, 1997, 111 Stat. 286; amended Pub. L. 106-113, div. B, § 1000(a)(6) [title III, § 321(k)(6)(B), title V, §§ 518, 520(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A-367, 1501A-384, 1501A-385; Pub. L. 106-554, § 1(a)(6) [title V, § 521(b), title VI, §§ 611(b), 615, 616, 621(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A-543, 2763A-560, 2763A-561, 2763A-564; Pub. L. 108-173, title I, § 102(b), title II, §§ 211(j), 221(d)(3), 222(a)(2), (3), (h), (l)(1), 233(a)(1), (2), (c), title VII, § 722(a), (b), title IX, §§ 900(e)(1)(F), 940(b)(2)(A), 948(b)(2), Dec. 8, 2003, 117 Stat. 2153, 2180, 2193, 2195, 2196, 2204, 2206, 2209, 2347, 2348, 2371, 2417, 2426; Pub. L. 110-275, title I, §§ 125(b)(6), 162(a)(1)-(3)(A), 163(a), (b), 164(f)(1), 165(a), July 15, 2008, 122 Stat. 2519, 2569-2571, 2574, 2575; Pub. L. 111-148, title III, § 3202(a)(1), Mar. 23, 2010, 124 Stat. 454.)

REFERENCES IN TEXT

Section 2702 of the Public Health Service Act, referred to in subsec. (b)(1)(A), is section 2702 of act July 1, 1944, which was classified to section 300gg-1 of this title, was amended by Pub. L. 111-148, title I, § 1201(3), Mar. 23, 2010, 124 Stat. 154, and was transferred to subsecs. (d) to (f) of section 300gg-4 of this title, effective for plan years beginning on or after Jan. 1, 2014. A new section 2702 of act July 1, 1944, related to guaranteed availability of coverage, was added by Pub. L. 111-148, title I, § 1201(4), Mar. 23, 2010, 124 Stat. 156, effective for plan years beginning on or after Jan. 1, 2014, and is classified to section 300gg-1 of this title.

The Employee Retirement Income Security Act of 1974, referred to in subsec. (j)(3)(C), is Pub. L. 93-406, Sept. 2, 1974, 88 Stat. 832, as amended, which is classified principally to chapter 18 (§ 1001 et seq.) of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

Section 1395w-104(c)(2)(E) of this title, referred to in subsec. (j)(7)(C), was redesignated section 1395w-104(c)(2)(G) of this title by Pub. L. 111-148, title X, § 10328(a)(1), Mar. 23, 2010, 124 Stat. 964.

AMENDMENTS

2010—Subsec. (a)(1)(B)(i). Pub. L. 111-148, § 3202(a)(1)(A), inserted “, subject to clause (iii),” after “and B or”.

Subsec. (a)(1)(B)(iii) to (v). Pub. L. 111-148, § 3202(a)(1)(B), added cls. (iii) to (v).

2008—Subsec. (a)(7). Pub. L. 110-275, § 165(a), added par. (7).

Subsec. (d)(4). Pub. L. 110-275, § 162(a)(1)(A), (2)(A), in introductory provisions, substituted “Subject to paragraphs (5) and (6), the Secretary” for “The Secretary” in second sentence.

Subsec. (d)(4)(B). Pub. L. 110-275, § 162(a)(3)(A), substituted “a sufficient number and range of providers within such category to meet the access standards in subparagraphs (A) through (E) of paragraph (1)” for “a sufficient number and range of providers within such category to provide covered services under the terms of the plan”.

Subsec. (d)(5). Pub. L. 110-275, § 162(a)(1)(B), added par. (5).

Subsec. (d)(6). Pub. L. 110-275, § 162(a)(2)(B), added par. (6).

Subsec. (e)(1). Pub. L. 110-275, § 163(a), struck out “(other than an MA private fee-for-service plan or an MSA plan)” before period at end.

Subsec. (e)(3)(A)(i). Pub. L. 110-275, § 163(b)(1), inserted at end “With respect to MA private fee-for-service plans and MSA plans, the requirements under the preceding sentence may not exceed the requirements under this subparagraph with respect to MA local plans that are preferred provider organization plans, except that, for plan year 2010, the limitation under clause (iii) shall not apply and such requirements shall apply only with respect to administrative claims data.”

Subsec. (e)(3)(A)(ii). Pub. L. 110-275, § 163(b)(2), 164(f)(1), added cl. (ii) and struck out former cl. (ii). Prior to amendment, text read as follows: “The Secretary shall establish as appropriate by regulation requirements for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality for MA organizations with respect to MA regional plans. Such requirements may not exceed the requirements under this subparagraph with respect to MA local plans that are preferred provider organization plans.”

Subsec. (e)(3)(A)(iii). Pub. L. 110-275, § 163(b)(3), inserted “local” after “to” and “and MA regional plans” after “organizations” in heading and “and to MA regional plans” after “organization plans” in text.

Subsec. (e)(4)(C). Pub. L. 110-275, § 125(b)(6), substituted “section 1395bb(a)(2)” for “section 1395bb(b)(2)”.

2003—Subsec. (a)(1). Pub. L. 108-173, § 222(a)(2), substituted “Requirement” for “In general” in par. heading, designated existing provisions as subpar. (A), inserted heading, substituted “chapter, benefits under the original medicare fee-for-service program option (and, for plan years before 2006, additional benefits required under section 1395w-24(f)(1)(A) of this title)” for “chapter—”, added subpar. (B), and struck out former subpars. (A) and (B) which read as follows:

“(A) those items and services (other than hospice care) for which benefits are available under parts A and B of this subchapter to individuals residing in the area served by the plan, and

“(B) additional benefits required under section 1395w-24(f)(1)(A) of this title.”

Pub. L. 108-173, § 221(d)(3)(A), inserted “and except as provided in paragraph (6) for MA regional plans” after “MSA plans” in introductory provisions.

Subsec. (a)(2)(C). Pub. L. 108-173, § 948(b)(2), substituted “determination” for “policy” wherever appearing in heading and text.

Subsec. (a)(3)(C). Pub. L. 108-173, § 222(a)(3), inserted at end “Such benefits may include reductions in cost-sharing below the actuarial value specified in section 1395w-24(e)(4)(B) of this title.”

Subsec. (a)(5). Pub. L. 108-173, § 900(e)(1)(F), substituted “Centers for Medicare & Medicaid Services” for “Health Care Financing Administration” in concluding provisions.

Subsec. (a)(6). Pub. L. 108-173, § 221(d)(3)(B), added par. (6).

Subsec. (b)(1)(A). Pub. L. 108-173, § 222(l)(1), inserted at end “The Secretary shall not approve a plan of an organization if the Secretary determines that the design of the plan and its benefits are likely to substantially discourage enrollment by certain MA eligible individuals with the organization.”

Subsec. (c)(1)(I). Pub. L. 108-173, § 722(b), amended heading and text of subpar. (I) generally. Prior to amendment, text read as follows: “A description of the organization’s quality assurance program under subsection (e) of this section, if required under such section.”

Pub. L. 108-173, § 233(a)(2)(A), inserted “, if required under such section” before period at end.

Subsec. (d)(4). Pub. L. 108-173, § 211(j)(2), inserted before period at end of concluding provisions “, except that, if a plan entirely meets such requirement with respect to a category of health care professional or provider on the basis of subparagraph (B), it may provide for a higher beneficiary copayment in the case of health care professionals and providers of that category who do not have contracts or agreements (other than deemed contracts or agreements under subsection (j)(6) of this section) to provide covered services under the terms of the plan”.

Subsec. (d)(4)(B). Pub. L. 108-173, § 211(j)(1), inserted “(other than deemed contracts or agreements under subsection (j)(6) of this section)” after “the plan has contracts or agreements”.

Subsec. (e). Pub. L. 108-173, § 722(a)(1), substituted “improvement” for “assurance” in heading.

Subsec. (e)(1). Pub. L. 108-173, § 722(a)(2), reenacted heading without change and amended text generally. Prior to amendment, text read as follows: “Each Medicare+Choice organization must have arrangements, consistent with any regulation, for an ongoing quality assurance program for health care services it provides to individuals enrolled with Medicare+Choice plans (other than MSA plans) of the organization.”

Pub. L. 108-173, § 233(a)(1), inserted “(other than MSA plans)” after “plans”.

Subsec. (e)(2). Pub. L. 108-173, § 722(a)(2), amended par. (2) generally, substituting provisions relating to chronic care improvement programs for provisions relating to elements of the quality assurance program of an organization with respect to a Medicare+Choice plan.

Subsec. (e)(2)(A). Pub. L. 108-173, § 233(a)(2)(B), struck out “, a non-network MSA plan,” after “fee-for-service plan” in introductory provisions.

Subsec. (e)(2)(B). Pub. L. 108-173, § 233(a)(2)(C), struck out “, non-network MSA plans,” after “fee-for-service plans” in heading and “, a non-network MSA plan,” after “fee-for-service plan” in introductory provisions.

Subsec. (e)(3). Pub. L. 108-173, § 722(a)(2), amended par. (3) generally, substituting provisions relating to collection, analysis, and reporting of data for provisions relating to external review by an independent quality review and improvement organization.

Subsec. (e)(4)(B)(i). Pub. L. 108-173, § 722(a)(3)(A), amended cl. (i) generally. Prior to amendment, cl. (i) read as follows: “Paragraphs (1) and (2) of this subsection (relating to quality assurance programs).”

Subsec. (e)(4)(B)(vii). Pub. L. 108-173, § 722(a)(3)(B), added cl. (vii).

Subsec. (e)(5). Pub. L. 108-173, § 722(a)(4), struck out par. (5), which related to report to be submitted to Congress not later than 2 years after Dec. 21, 2000, and biennially thereafter, regarding how quality assurance programs focus on racial and ethnic minorities.

Subsec. (g)(5). Pub. L. 108-173, § 940(b)(2)(A), inserted at end “The provisions of section 1395ff(b)(1)(E)(iii) of this title shall apply with respect to dollar amounts specified in the first 2 sentences of this paragraph in the same manner as they apply to the dollar amounts specified in section 1395ff(b)(1)(E)(i) of this title.”

Subsec. (j)(4)(A). Pub. L. 108-173, § 222(h)(1), inserted “the organization provides assurances satisfactory to the Secretary that” after “unless” in introductory provisions.

Subsec. (j)(4)(A)(ii). Pub. L. 108-173, § 222(h)(2), substituted “the organization” for “the organization—”, struck out subcl. (I) designation before “provides”, substituted period for “, and” at end of subcl. (I), and struck out subcl. (II), which read as follows: “conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.”

Subsec. (j)(4)(A)(iii). Pub. L. 108-173, § 222(h)(3), struck out cl. (iii) which read as follows: “The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph.”

Subsec. (j)(7). Pub. L. 108-173, § 102(b), added par. (7).

Subsec. (k)(1). Pub. L. 108-173, § 233(c), inserted “or with an organization offering an MSA plan” after “section 1395w-21(a)(2)(A) of this title”.

2000—Subsec. (a)(2)(C). Pub. L. 106-554, § 1(a)(6) [title VI, § 615], added subpar. (C).

Subsec. (a)(5). Pub. L. 106-554, § 1(a)(6) [title VI, § 611(b)(5)], inserted concluding provisions.

Pub. L. 106-554, § 1(a)(6) [title VI, § 611(b)(1), (2)], inserted “and legislative changes in benefits” after “National coverage determinations” in heading and inserted “or legislative change in benefits required to be provided under this part” after “there is a national coverage determination” in introductory provisions.

Subsec. (a)(5)(A). Pub. L. 106-554, § 1(a)(6) [title VI, § 611(b)(3)], inserted “or legislative change in benefits” after “such determination”.

Subsec. (a)(5)(B). Pub. L. 106-554, § 1(a)(6) [title VI, § 611(b)(4)], inserted “or legislative change” after “if such coverage determination”.

Subsec. (e)(2)(A), (B). Pub. L. 106-554, § 1(a)(6) [title VI, § 616(a)], inserted concluding provisions.

Subsec. (e)(5). Pub. L. 106-554, § 1(a)(6) [title VI, § 616(b)], added par. (5).

Subsec. (g)(4). Pub. L. 106-554, § 1(a)(6) [title V, § 521(b)], inserted at end “The provisions of section 1395ff(c)(5) of this title shall apply to independent outside entities under contract with the Secretary under this paragraph.”

Subsec. (l). Pub. L. 106-554, § 1(a)(6) [title VI, § 621(a)], added subsec. (l).

1999—Subsec. (a)(3)(A). Pub. L. 106-113, § 1000(a)(6) [title III, § 321(k)(6)(B)(i)], struck out comma after “MSA plan” and inserted comma after “the coverage”.

Subsec. (e)(2)(A). Pub. L. 106-113, § 1000(a)(6) [title V, § 520(a)(1)], substituted “, a non-network MSA plan, or a preferred provider organization plan” for “or a non-network MSA plan” in introductory provisions.

Subsec. (e)(2)(B). Pub. L. 106-113, § 1000(a)(6) [title V, § 520(a)(2)], substituted “, non-network MSA plans, and preferred provider organization plans” for “and non-network MSA plans” in heading and “, a non-network MSA plan, or a preferred provider organization plan” for “or a non-network MSA plan” in introductory provisions.

Subsec. (e)(2)(D). Pub. L. 106-113, § 1000(a)(6) [title V, § 520(a)(3)], added subpar. (D).

Subsec. (e)(4). Pub. L. 106-113, § 1000(a)(6) [title V, § 518], amended heading and text of par. (4) generally.

Prior to amendment, text read as follows: “The Secretary shall provide that a Medicare+Choice organization is deemed to meet requirements of paragraphs (1) and (2) of this subsection and subsection (h) of this section (relating to confidentiality and accuracy of enrollee records) if the organization is accredited (and periodically reaccredited) by a private organization under a process that the Secretary has determined assures that the organization, as a condition of accreditation, applies and enforces standards with respect to the requirements involved that are no less stringent than the standards established under section 1395w-26 of this title to carry out the respective requirements.”

Subsec. (g)(1)(B). Pub. L. 106-113, §1000(a)(6) [title III, §321(k)(6)(B)(ii)(I)], inserted “or” after “in whole”.

Subsec. (g)(3)(B)(ii). Pub. L. 106-113, §1000(a)(6) [title III, §321(k)(6)(B)(ii)(II)], inserted period at end.

Subsec. (h)(2). Pub. L. 106-113, §1000(a)(6) [title III, §321(k)(6)(B)(iii)], substituted a semicolon for a comma before “and”.

Subsec. (k)(2)(C)(ii). Pub. L. 106-113, §1000(a)(6) [title III, §321(k)(6)(B)(iv)], substituted “balance” for “balancing” before “billing under subparagraph (A) could” in introductory provisions.

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108-173, set out as a note under section 1395w-21 of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111-148, title III, §3202(a)(2), Mar. 23, 2010, 124 Stat. 454, provided that: “The amendments made by this subsection [amending this section] shall apply to plan years beginning on or after January 1, 2011.”

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by section 125(b)(6) of Pub. L. 110-275 applicable with respect to accreditations of hospitals granted on or after the date that is 24 months after July 15, 2008, with transition rule, see section 125(d) of Pub. L. 110-275, set out as an Effective Date of 2008 Amendment; Transition Rule note under section 1395bb of this title.

Pub. L. 110-275, title I, §162(a)(3)(B), July 15, 2008, 122 Stat. 2571, provided that: “The amendment made by subparagraph (A) [amending this section] shall apply to plan year 2010 and subsequent plan years.”

Pub. L. 110-275, title I, §163(c), July 15, 2008, 122 Stat. 2571, provided that: “The amendments made by this section [amending this section] shall apply to plan years beginning on or after January 1, 2010.”

Pub. L. 110-275, title I, §164(f)(2), July 15, 2008, 122 Stat. 2575, provided that: “The amendment made by paragraph (1) [amending this section] shall take effect on a date specified by the Secretary of Health and Human Services (but in no case later than January 1, 2010), and shall apply to all specialized Medicare Advantage plans for special needs individuals regardless of when the plan first entered the Medicare Advantage program under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w-21 et seq.]”

Pub. L. 110-275, title I, §165(b), July 15, 2008, 122 Stat. 2575, provided that: “The amendment made by subsection (a) [amending this section] shall apply to plan years beginning on or after January 1, 2010.”

EFFECTIVE AND TERMINATION DATES OF 2003 AMENDMENT

Amendment by sections 221(d)(3) and 222(a)(2), (3), (h), (i)(1) of Pub. L. 108-173 applicable with respect to plan years beginning on or after Jan. 1, 2006, see section 223(a) of Pub. L. 108-173, set out as an Effective Date of 2003 Amendment note under section 1395w-21 of this title.

Pub. L. 108-173, title II, §233(a)(3), Dec. 8, 2003, 117 Stat. 2209, provided that: “The amendments made by

this subsection [amending this section] shall apply on and after the date of the enactment of this Act [Dec. 8, 2003] but shall not apply to contract years beginning on or after January 1, 2006.”

Pub. L. 108-173, title VII, §722(c), Dec. 8, 2003, 117 Stat. 2348, provided that: “The amendments made by this section [amending this section] shall apply with respect to contract years beginning on and after January 1, 2006.”

Amendment by section 948(b)(2) of Pub. L. 108-173 effective, except as otherwise provided, as if included in the enactment of BIPA (the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, H.R. 5661, as enacted by section 1(a)(6) of Public Law 106-554, see section 948(e) of Pub. L. 108-173, set out as an Effective Date of 2003 Amendment note under section 1314 of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by section 1(a)(6) [title V, §521(b)] of Pub. L. 106-554 applicable with respect to initial determinations made on or after Oct. 1, 2002, see section 1(a)(6) [title V, §521(d)] of Pub. L. 106-554, set out as a note under section 1320c-3 of this title.

Pub. L. 106-554, §1(a)(6) [title VI, §611(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A-560, provided that: “The amendments made by this section [amending this section and section 1395w-23 of this title] are effective on the date of the enactment of this Act [Dec. 21, 2000] and shall apply to national coverage determinations and legislative changes in benefits occurring on or after such date.”

Pub. L. 106-554, §1(a)(6) [title VI, §621(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-565, provided that: “The amendment made by subsection (a) [amending this section] shall apply with respect to contracts entered into or renewed on or after the date of the enactment of this Act [Dec. 21, 2000].”

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 1000(a)(6) [title III, §321(k)(6)(B)] of Pub. L. 106-113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105-33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106-113, set out as a note under section 1395d of this title.

Pub. L. 106-113, div. B, §1000(a)(6) [title V, §520(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A-386, provided that: “The amendments made by subsection (a) [amending this section] apply to contract years beginning on or after January 1, 2000.”

MEDPAC STUDY

Pub. L. 106-554, §1(a)(6) [title VI, §621(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A-565, provided that:

“(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study analyzing the effects of the amendment made by subsection (a) [amending this section] on Medicare+Choice organizations. In conducting such study, the Commission shall examine the effects (if any) such amendment has had—

“(A) on the scope of additional benefits provided under the Medicare+Choice program;

“(B) on the administrative and other costs incurred by Medicare+Choice organizations; and

“(C) on the contractual relationships between such organizations and skilled nursing facilities.

“(2) REPORT.—Not later than 2 years after the date of the enactment of this Act [Dec. 21, 2000], the Commission shall submit to Congress a report on the study conducted under paragraph (1).”

TRANSITIONAL PASS-THROUGH OF ADDITIONAL COSTS UNDER MEDICARE+CHOICE PROGRAM FOR 2000

Pub. L. 106-113, div. B, §1000(a)(6) [title II, §227(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A-355, provided that: “The provisions of subparagraphs (A) and (B) of section 1852(a)(5) of the Social Security Act (42 U.S.C. 1395w-22(a)(5)) shall apply with respect to the coverage

of additional benefits for immunosuppressive drugs under the amendments made by this section [amending sections 1395k and 1395x of this title] for drugs furnished in 2000 in the same manner as if such amendments constituted a national coverage determination described in the matter in such section before subparagraph (A).”

§ 1395w-23. Payments to Medicare+Choice organizations

(a) Payments to organizations

(1) Monthly payments

(A) In general

Under a contract under section 1395w-27 of this title and subject to subsections (e), (g), (i), and (l) of this section and section 1395w-28(e)(4) of this title, the Secretary shall make monthly payments under this section in advance to each Medicare+Choice organization, with respect to coverage of an individual under this part in a Medicare+Choice payment area for a month, in an amount determined as follows:

(i) Payment before 2006

For years before 2006, the payment amount shall be equal to $\frac{1}{2}$ of the annual MA capitation rate (as calculated under subsection (c)(1) of this section) with respect to that individual for that area, adjusted under subparagraph (C) and reduced by the amount of any reduction elected under section 1395w-24(f)(1)(E) of this title.

(ii) Payment for original fee-for-service benefits beginning with 2006

For years beginning with 2006, the amount specified in subparagraph (B).

(B) Payment amount for original fee-for-service benefits beginning with 2006

(i) Payment of bid for plans with bids below benchmark

In the case of a plan for which there are average per capita monthly savings described in section 1395w-24(b)(3)(C) or 1395w-24(b)(4)(C) of this title, as the case may be, the amount specified in this subparagraph is equal to the unadjusted MA statutory non-drug monthly bid amount, adjusted under subparagraph (C) and (if applicable) under subparagraphs (F) and (G), plus the amount (if any) of any rebate under subparagraph (E).

(ii) Payment of benchmark for plans with bids at or above benchmark

In the case of a plan for which there are no average per capita monthly savings described in section 1395w-24(b)(3)(C) or 1395w-24(b)(4)(C) of this title, as the case may be, the amount specified in this subparagraph is equal to the MA area-specific non-drug monthly benchmark amount, adjusted under subparagraph (C) and (if applicable) under subparagraphs (F) and (G).

(iii) Payment of benchmark for MSA plans

Notwithstanding clauses (i) and (ii), in the case of an MSA plan, the amount specified in this subparagraph is equal to the MA area-specific non-drug monthly bench-

mark amount, adjusted under subparagraph (C).

(iv) Authority to apply frailty adjustment under PACE payment rules for certain specialized MA plans for special needs individuals

(I) In general

Notwithstanding the preceding provisions of this paragraph, for plan year 2011 and subsequent plan years, in the case of a plan described in subclause (II), the Secretary may apply the payment rules under section 1395eee(d) of this title (other than paragraph (3) of such section) rather than the payment rules that would otherwise apply under this part, but only to the extent necessary to reflect the costs of treating high concentrations of frail individuals.

(II) Plan described

A plan described in this subclause is a specialized MA plan for special needs individuals described in section 1395w-28(b)(6)(B)(ii) of this title that is fully integrated with capitated contracts with States for Medicaid benefits, including long-term care, and that have similar average levels of frailty (as determined by the Secretary) as the PACE program.

(C) Demographic adjustment, including adjustment for health status

(i) In general

The Secretary shall adjust the payment amount under subparagraph (A)(i) and the amount specified under subparagraph (B)(i), (B)(ii), and (B)(iii) for such risk factors as age, disability status, gender, institutional status, and such other factors as the Secretary determines to be appropriate, including adjustment for health status under paragraph (3), so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such adjustment factors if such changes will improve the determination of actuarial equivalence.

(ii) Application of coding adjustment

For 2006 and each subsequent year:

(I) In applying the adjustment under clause (i) for health status to payment amounts, the Secretary shall ensure that such adjustment reflects changes in treatment and coding practices in the fee-for-service sector and reflects differences in coding patterns between Medicare Advantage plans and providers under part¹ A and B to the extent that the Secretary has identified such differences.

(II) In order to ensure payment accuracy, the Secretary shall annually conduct an analysis of the differences described in subclause (I). The Secretary shall complete such analysis by a date necessary to ensure that the results of

¹ So in original. Probably should be “parts”.

such analysis are incorporated on a timely basis into the risk scores for 2008 and subsequent years. In conducting such analysis, the Secretary shall use data submitted with respect to 2004 and subsequent years, as available and updated as appropriate.

(III) In calculating each year's adjustment, the adjustment factor shall be for 2014, not less than the adjustment factor applied for 2010, plus 1.5 percentage points; for each of years 2015 through 2018, not less than the adjustment factor applied for the previous year, plus 0.25 percentage point; and for 2019 and each subsequent year, not less than 5.9 percent.

(IV) Such adjustment shall be applied to risk scores until the Secretary implements risk adjustment using Medicare Advantage diagnostic, cost, and use data.

(iii) Improvements to risk adjustment for special needs individuals with chronic health conditions

(I) In general

For 2011 and subsequent years, for purposes of the adjustment under clause (i) with respect to individuals described in subclause (II), the Secretary shall use a risk score that reflects the known underlying risk profile and chronic health status of similar individuals. Such risk score shall be used instead of the default risk score for new enrollees in Medicare Advantage plans that are not specialized MA plans for special needs individuals (as defined in section 1395w-28(b)(6) of this title).

(II) Individuals described

An individual described in this subclause is a special needs individual described in subsection (b)(6)(B)(iii)² who enrolls in a specialized MA plan for special needs individuals on or after January 1, 2011.

(III) Evaluation

For 2011 and periodically thereafter, the Secretary shall evaluate and revise the risk adjustment system under this subparagraph in order to, as accurately as possible, account for higher medical and care coordination costs associated with frailty, individuals with multiple, comorbid chronic conditions, and individuals with a diagnosis of mental illness, and also to account for costs that may be associated with higher concentrations of beneficiaries with those conditions.

(IV) Publication of evaluation and revisions

The Secretary shall publish, as part of an announcement under subsection (b), a description of any evaluation conducted under subclause (III) during the preced-

ing year and any revisions made under such subclause as a result of such evaluation.

(D) Separate payment for Federal drug subsidies

In the case of an enrollee in an MA-PD plan, the MA organization offering such plan also receives—

- (i) subsidies under section 1395w-115 of this title (other than under subsection (g)); and
- (ii) reimbursement for premium and cost-sharing reductions for low-income individuals under section 1395w-114(c)(1)(C) of this title.

(E) Payment of rebate for plans with bids below benchmark

In the case of a plan for which there are average per capita monthly savings described in section 1395w-24(b)(3)(C) or 1395w-24(b)(4)(C) of this title, as the case may be, the amount specified in this subparagraph is the amount of the monthly rebate computed under section 1395w-24(b)(1)(C)(i) of this title for that plan and year (as reduced by the amount of any credit provided under section 1395w-24(b)(1)(C)(iv)² of this title).

(F) Adjustment for intra-area variations

(i) Intra-regional variations

In the case of payment with respect to an MA regional plan for an MA region, the Secretary shall also adjust the amounts specified under subparagraphs (B)(i) and (B)(ii) in a manner to take into account variations in MA local payment rates under this part among the different MA local areas included in such region.

(ii) Intra-service area variations

In the case of payment with respect to an MA local plan for a service area that covers more than one MA local area, the Secretary shall also adjust the amounts specified under subparagraphs (B)(i) and (B)(ii) in a manner to take into account variations in MA local payment rates under this part among the different MA local areas included in such service area.

(G) Adjustment relating to risk adjustment

The Secretary shall adjust payments with respect to MA plans as necessary to ensure that—

- (i) the sum of—
 - (I) the monthly payment made under subparagraph (A)(ii); and
 - (II) the MA monthly basic beneficiary premium under section 1395w-24(b)(2)(A) of this title; equals
- (ii) the unadjusted MA statutory non-drug monthly bid amount, adjusted in the manner described in subparagraph (C) and, for an MA regional plan, subparagraph (F).

(H) Special rule for end-stage renal disease

The Secretary shall establish separate rates of payment to a Medicare+Choice organization with respect to classes of individ-

² See References in Text note below.

uals determined to have end-stage renal disease and enrolled in a Medicare+Choice plan of the organization. Such rates of payment shall be actuarially equivalent to rates that would have been paid with respect to other enrollees in the MA payment area (or such other area as specified by the Secretary) under the provisions of this section as in effect before December 8, 2003. In accordance with regulations, the Secretary shall provide for the application of the seventh sentence of section 1395rr(b)(7) of this title to payments under this section covering the provision of renal dialysis treatment in the same manner as such sentence applies to composite rate payments described in such sentence. In establishing such rates, the Secretary shall provide for appropriate adjustments to increase each rate to reflect the demonstration rate (including the risk adjustment methodology associated with such rate) of the social health maintenance organization end-stage renal disease capitation demonstrations (established by section 2355 of the Deficit Reduction Act of 1984, as amended by section 13567(b) of the Omnibus Budget Reconciliation Act of 1993), and shall compute such rates by taking into account such factors as renal treatment modality, age, and the underlying cause of the end-stage renal disease. The Secretary may apply the competitive bidding methodology provided for in this section, with appropriate adjustments to account for the risk adjustment methodology applied to end stage renal disease payments.

(2) Adjustment to reflect number of enrollees

(A) In general

The amount of payment under this subsection may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled with an organization under this part and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

(B) Special rule for certain enrollees

(i) In general

Subject to clause (ii), the Secretary may make retroactive adjustments under subparagraph (A) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with a Medicare+Choice organization under a plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the organization under this part, except that for purposes of making such retroactive adjustments under this subparagraph, such period may not exceed 90 days.

(ii) Exception

No adjustment may be made under clause (i) with respect to any individual who does not certify that the organization

provided the individual with the disclosure statement described in section 1395w-22(c) of this title at the time the individual enrolled with the organization.

(3) Establishment of risk adjustment factors

(A) Report

The Secretary shall develop, and submit to Congress by not later than March 1, 1999, a report on the method of risk adjustment of payment rates under this section, to be implemented under subparagraph (C), that accounts for variations in per capita costs based on health status. Such report shall include an evaluation of such method by an outside, independent actuary of the actuarial soundness of the proposal.

(B) Data collection

In order to carry out this paragraph, the Secretary shall require Medicare+Choice organizations (and eligible organizations with risk-sharing contracts under section 1395mm of this title) to submit data regarding inpatient hospital services for periods beginning on or after July 1, 1997, and data regarding other services and other information as the Secretary deems necessary for periods beginning on or after July 1, 1998. The Secretary may not require an organization to submit such data before January 1, 1998.

(C) Initial implementation

(i) In general

The Secretary shall first provide for implementation of a risk adjustment methodology that accounts for variations in per capita costs based on health status and other demographic factors for payments by no later than January 1, 2000.

(ii) Phase-in

Except as provided in clause (iv), such risk adjustment methodology shall be implemented in a phased-in manner so that the methodology insofar as it makes adjustments to capitation rates for health status applies to—

(I) 10 percent of $\frac{1}{2}$ of the annual Medicare+Choice capitation rate in 2000 and each succeeding year through 2003;

(II) 30 percent of such capitation rate in 2004;

(III) 50 percent of such capitation rate in 2005;

(IV) 75 percent of such capitation rate in 2006; and

(V) 100 percent of such capitation rate in 2007 and succeeding years.

(iii) Data for risk adjustment methodology

Such risk adjustment methodology for 2004 and each succeeding year, shall be based on data from inpatient hospital and ambulatory settings.

(iv) Full implementation of risk adjustment for congestive heart failure enrollees for 2001

(I) Exemption from phase-in

Subject to subclause (II), the Secretary shall fully implement the risk adjust-

ment methodology described in clause (i) with respect to each individual who has had a qualifying congestive heart failure inpatient diagnosis (as determined by the Secretary under such risk adjustment methodology) during the period beginning on July 1, 1999, and ending on June 30, 2000, and who is enrolled in a coordinated care plan that is the only coordinated care plan offered on January 1, 2001, in the service area of the individual.

(II) Period of application

Subclause (I) shall only apply during the 1-year period beginning on January 1, 2001.

(D) Uniform application to all types of plans

Subject to section 1395w-28(e)(4) of this title, the methodology shall be applied uniformly without regard to the type of plan.

(4) Payment rule for federally qualified health center services

If an individual who is enrolled with an MA plan under this part receives a service from a federally qualified health center that has a written agreement with the MA organization that offers such plan for providing such a service (including any agreement required under section 1395w-27(e)(3) of this title)—

(A) the Secretary shall pay the amount determined under section 1395f(a)(3)(B) of this title directly to the federally qualified health center not less frequently than quarterly; and

(B) the Secretary shall not reduce the amount of the monthly payments under this subsection as a result of the application of subparagraph (A).

(b) Annual announcement of payment rates

(1) Annual announcements

(A) For 2005

The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), not later than the second Monday in May of 2004, with respect to each MA payment area, the following:

(i) MA capitation rates

The annual MA capitation rate for each MA payment area for 2005.

(ii) Adjustment factors

The risk and other factors to be used in adjusting such rates under subsection (a)(1)(C) of this section for payments for months in 2005.

(B) For 2006 and subsequent years

For a year after 2005—

(i) Initial announcement

The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), not later than the first Monday in April before the calendar year concerned, with respect to each MA payment area, the following:

(I) MA capitation rates; MA local area benchmark

The annual MA capitation rate for each MA payment area for the year.

(II) Adjustment factors

The risk and other factors to be used in adjusting such rates under subsection (a)(1)(C) of this section for payments for months in such year.

(ii) Regional benchmark announcement

The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), on a timely basis before the calendar year concerned, with respect to each MA region and each MA regional plan for which a bid was submitted under section 1395w-24 of this title, the MA region-specific non-drug monthly benchmark amount for that region for the year involved.

(iii) Benchmark announcement for CCA local areas

The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), on a timely basis before the calendar year concerned, with respect to each CCA area (as defined in section 1395w-29(b)(1)(A)² of this title), the CCA non-drug monthly benchmark amount under section 1395w-29(e)(1)² of this title for that area for the year involved.

(2) Advance notice of methodological changes

At least 45 days (or, in 2017 and each subsequent year, at least 60 days) before making the announcement under paragraph (1) for a year, the Secretary shall provide for notice to Medicare+Choice organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity (in 2017 and each subsequent year, of no less than 30 days) to comment on such proposed changes.

(3) Explanation of assumptions

In each announcement made under paragraph (1), the Secretary shall include an explanation of the assumptions and changes in methodology used in such announcement.

(4) Continued computation and publication of county-specific per capita fee-for-service expenditure information

The Secretary, through the Chief Actuary of the Centers for Medicare & Medicaid Services, shall provide for the computation and publication, on an annual basis beginning with 2001 at the time of publication of the annual Medicare+Choice capitation rates under paragraph (1), of the following information for the original medicare fee-for-service program under parts A and B of this subchapter (exclusive of individuals eligible for coverage under section 426-1 of this title) for each Medicare+Choice payment area for the second calendar year ending before the date of publication:

(A) Total expenditures per capita per month, computed separately for part A of

this subchapter and for part B of this subchapter.

(B) The expenditures described in subparagraph (A) reduced by the best estimate of the expenditures (such as graduate medical education and disproportionate share hospital payments) not related to the payment of claims.

(C) The average risk factor for the covered population based on diagnoses reported for medicare inpatient services, using the same methodology as is expected to be applied in making payments under subsection (a) of this section.

(D) Such average risk factor based on diagnoses for inpatient and other sites of service, using the same methodology as is expected to be applied in making payments under subsection (a) of this section.

(c) Calculation of annual Medicare+Choice capitation rates

(1) In general

For purposes of this part, subject to paragraphs (6)(C) and (7), each annual Medicare+Choice capitation rate, for a Medicare+Choice payment area that is an MA local area for a contract year consisting of a calendar year, is equal to the largest of the amounts specified in the following subparagraph (A), (B), (C), or (D):

(A) Blended capitation rate

For a year before 2005, the sum of—

(i) the area-specific percentage (as specified under paragraph (2) for the year) of the annual area-specific Medicare+Choice capitation rate for the Medicare+Choice payment area, as determined under paragraph (3) for the year, and

(ii) the national percentage (as specified under paragraph (2) for the year) of the input-price-adjusted annual national Medicare+Choice capitation rate, as determined under paragraph (4) for the year,

multiplied (for a year other than 2004) by the budget neutrality adjustment factor determined under paragraph (5).

(B) Minimum amount

12 multiplied by the following amount:

(i) For 1998, \$367 (but not to exceed, in the case of an area outside the 50 States and the District of Columbia, 150 percent of the annual per capita rate of payment for 1997 determined under section 1395mm(a)(1)(C) of this title for the area).

(ii) For 1999 and 2000, the minimum amount determined under clause (i) or this clause, respectively, for the preceding year, increased by the national per capita Medicare+Choice growth percentage described in paragraph (6)(A) applicable to 1999 or 2000, respectively.

(iii)(I) Subject to subclause (II), for 2001, for any area in a Metropolitan Statistical Area with a population of more than 250,000, \$525, and for any other area \$475.

(II) In the case of an area outside the 50 States and the District of Columbia, the amount specified in this clause shall not

exceed 120 percent of the amount determined under clause (ii) for such area for 2000.

(iv) For 2002, 2003, and 2004, the minimum amount specified in this clause (or clause (iii)) for the preceding year increased by the national per capita Medicare+Choice growth percentage, described in paragraph (6)(A) for that succeeding year.

(C) Minimum percentage increase

(i) For 1998, 102 percent of the annual per capita rate of payment for 1997 determined under section 1395mm(a)(1)(C) of this title for the Medicare+Choice payment area.

(ii) For 1999 and 2000, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

(iii) For 2001, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2000.

(iv) For 2002 and 2003, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

(v) For 2004 and each succeeding year, the greater of—

(I) 102 percent of the annual MA capitation rate under this paragraph for the area for the previous year; or

(II) the annual MA capitation rate under this paragraph for the area for the previous year increased by the national per capita MA growth percentage, described in paragraph (6) for that succeeding year, but not taking into account any adjustment under paragraph (6)(C) for a year before 2004.

(D) 100 percent of fee-for-service costs

(i) In general

For each year specified in clause (ii), the adjusted average per capita cost for the year involved, determined under section 1395mm(a)(4) of this title and adjusted as appropriate for the purpose of risk adjustment, for the MA payment area for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under sections,³ 1395w-4(o), and³ 1395ww(n) and 1395ww(h) of this title.

(ii) Periodic rebasing

The provisions of clause (i) shall apply for 2004 and for subsequent years as the Secretary shall specify (but not less than once every 3 years).

(iii) Inclusion of costs of VA and DOD military facility services to medicare-eligible beneficiaries

In determining the adjusted average per capita cost under clause (i) for a year, such cost shall be adjusted to include the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this subchapter if individuals enti-

³ So in original.

tled to benefits under this subchapter had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

(2) Area-specific and national percentages

For purposes of paragraph (1)(A)—

(A) for 1998, the “area-specific percentage” is 90 percent and the “national percentage” is 10 percent,

(B) for 1999, the “area-specific percentage” is 82 percent and the “national percentage” is 18 percent,

(C) for 2000, the “area-specific percentage” is 74 percent and the “national percentage” is 26 percent,

(D) for 2001, the “area-specific percentage” is 66 percent and the “national percentage” is 34 percent,

(E) for 2002, the “area-specific percentage” is 58 percent and the “national percentage” is 42 percent, and

(F) for a year after 2002, the “area-specific percentage” is 50 percent and the “national percentage” is 50 percent.

(3) Annual area-specific Medicare+Choice capitation rate

(A) In general

For purposes of paragraph (1)(A), subject to subparagraphs (B) and (E), the annual area-specific Medicare+Choice capitation rate for a Medicare+Choice payment area—

(i) for 1998 is, subject to subparagraph (D), the annual per capita rate of payment for 1997 determined under section 1395mm(a)(1)(C) of this title for the area, increased by the national per capita Medicare+Choice growth percentage for 1998 (described in paragraph (6)(A)); or

(ii) for a subsequent year is the annual area-specific Medicare+Choice capitation rate for the previous year determined under this paragraph for the area, increased by the national per capita Medicare+Choice growth percentage for such subsequent year.

(B) Removal of medical education from calculation of adjusted average per capita cost

(i) In general

In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 1998), the annual per capita rate of payment for 1997 determined under section 1395mm(a)(1)(C) of this title shall be adjusted to exclude from the rate the applicable percent (specified in clause (ii)) of the payment adjustments described in subparagraph (C).

(ii) Applicable percent

For purposes of clause (i), the applicable percent for—

(I) 1998 is 20 percent,

(II) 1999 is 40 percent,

(III) 2000 is 60 percent,

(IV) 2001 is 80 percent, and

(V) a succeeding year is 100 percent.

(C) Payment adjustment

(i) In general

Subject to clause (ii), the payment adjustments described in this subparagraph are payment adjustments which the Secretary estimates were payable during 1997—

(I) for the indirect costs of medical education under section 1395ww(d)(5)(B) of this title, and

(II) for direct graduate medical education costs under section 1395ww(h) of this title.

(ii) Treatment of payments covered under State hospital reimbursement system

To the extent that the Secretary estimates that an annual per capita rate of payment for 1997 described in clause (i) reflects payments to hospitals reimbursed under section 1395f(b)(3) of this title, the Secretary shall estimate a payment adjustment that is comparable to the payment adjustment that would have been made under clause (i) if the hospitals had not been reimbursed under such section.

(D) Treatment of areas with highly variable payment rates

In the case of a Medicare+Choice payment area for which the annual per capita rate of payment determined under section 1395mm(a)(1)(C) of this title for 1997 varies by more than 20 percent from such rate for 1996, for purposes of this subsection the Secretary may substitute for such rate for 1997 a rate that is more representative of the costs of the enrollees in the area.

(E) Inclusion of costs of DOD and VA military facility services to Medicare-eligible beneficiaries

In determining the area-specific MA capitation rate under subparagraph (A) for a year (beginning with 2004), the annual per capita rate of payment for 1997 determined under section 1395mm(a)(1)(C) of this title shall be adjusted to include in the rate the Secretary’s estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this subchapter if individuals entitled to benefits under this subchapter had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

(4) Input-price-adjusted annual national Medicare+Choice capitation rate

(A) In general

For purposes of paragraph (1)(A), the input-price-adjusted annual national Medicare+Choice capitation rate for a Medicare+Choice payment area for a year is equal to the sum, for all the types of Medicare services (as classified by the Secretary), of the product (for each such type of service) of—

(i) the national standardized annual Medicare+Choice capitation rate (determined under subparagraph (B)) for the year,

(ii) the proportion of such rate for the year which is attributable to such type of services, and

(iii) an index that reflects (for that year and that type of services) the relative input price of such services in the area compared to the national average input price of such services.

In applying clause (iii), the Secretary may, subject to subparagraph (C), apply those indices under this subchapter that are used in applying (or updating) national payment rates for specific areas and localities.

(B) National standardized annual Medicare+Choice capitation rate

In subparagraph (A)(i), the “national standardized annual Medicare+Choice capitation rate” for a year is equal to—

(i) the sum (for all Medicare+Choice payment areas) of the product of—

(I) the annual area-specific Medicare+Choice capitation rate for that year for the area under paragraph (3), and

(II) the average number of medicare beneficiaries residing in that area in the year, multiplied by the average of the risk factor weights used to adjust payments under subsection (a)(1)(A) of this section for such beneficiaries in such area; divided by

(ii) the sum of the products described in clause (i)(II) for all areas for that year.

(C) Special rules for 1998

In applying this paragraph for 1998—

(i) medicare services shall be divided into 2 types of services: part A services and part B services;

(ii) the proportions described in subparagraph (A)(ii)—

(I) for part A services shall be the ratio (expressed as a percentage) of the national average annual per capita rate of payment for part A of this subchapter for 1997 to the total national average annual per capita rate of payment for parts A and B of this subchapter for 1997, and

(II) for part B services shall be 100 percent minus the ratio described in subclause (I);

(iii) for part A services, 70 percent of payments attributable to such services shall be adjusted by the index used under section 1395ww(d)(3)(E) of this title to adjust payment rates for relative hospital wage levels for hospitals located in the payment area involved;

(iv) for part B services—

(I) 66 percent of payments attributable to such services shall be adjusted by the index of the geographic area factors under section 1395w-4(e) of this title used to adjust payment rates for physicians’ services furnished in the payment area, and

(II) of the remaining 34 percent of the amount of such payments, 40 percent shall be adjusted by the index described in clause (iii); and

(v) the index values shall be computed based only on the beneficiary population who are 65 years of age or older and who are not determined to have end stage renal disease.

The Secretary may continue to apply the rules described in this subparagraph (or similar rules) for 1999.

(5) Payment adjustment budget neutrality factor

For purposes of paragraph (1)(A), for each year (other than 2004), the Secretary shall determine a budget neutrality adjustment factor so that the aggregate of the payments under this part (other than those attributable to subsections (a)(3)(C)(iv), (a)(4), and (i) of this section) shall equal the aggregate payments that would have been made under this part if payment were based entirely on area-specific capitation rates.

(6) “National per capita Medicare+Choice growth percentage” defined

(A) In general

In this part, the “national per capita Medicare+Choice growth percentage” for a year is the percentage determined by the Secretary, by March 1st before the beginning of the year involved, to reflect the Secretary’s estimate of the projected per capita rate of growth in expenditures under this subchapter for an individual entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter, excluding expenditures attributable to subsections (a)(7) and (o) of section 1395w-4 of this title and subsections (b)(3)(B)(ix) and (n) of section 1395ww of this title, reduced by the number of percentage points specified in subparagraph (B) for the year. Separate determinations may be made for aged enrollees, disabled enrollees, and enrollees with end-stage renal disease.

(B) Adjustment

The number of percentage points specified in this subparagraph is—

- (i) for 1998, 0.8 percentage points,
- (ii) for 1999, 0.5 percentage points,
- (iii) for 2000, 0.5 percentage points,
- (iv) for 2001, 0.5 percentage points,
- (v) for 2002, 0.3 percentage points, and
- (vi) for a year after 2002, 0 percentage points.

(C) Adjustment for over or under projection of national per capita Medicare+Choice growth percentage

Beginning with rates calculated for 1999, before computing rates for a year as described in paragraph (1), the Secretary shall adjust all area-specific and national Medicare+Choice capitation rates (and beginning in 2000, the minimum amount) for the previous year for the differences between the projections of the national per capita Medicare+Choice growth percentage for that year and previous years and the current estimate of such percentage for such years, except that for purposes of paragraph (1)(C)(v)(II), no such adjustment shall be made for a year before 2004.

(7) Adjustment for national coverage determinations and legislative changes in benefits

If the Secretary makes a determination with respect to coverage under this subchapter or there is a change in benefits required to be provided under this part that the Secretary projects will result in a significant increase in the costs to Medicare+Choice of providing benefits under contracts under this part (for periods after any period described in section 1395w-22(a)(5) of this title), the Secretary shall adjust appropriately the payments to such organizations under this part. Such projection and adjustment shall be based on an analysis by the Chief Actuary of the Centers for Medicare & Medicaid Services of the actuarial costs associated with the new benefits.

(d) MA payment area; MA local area; MA region defined

(1) MA payment area

In this part, except as provided in this subsection, the term “MA payment area” means—

(A) with respect to an MA local plan, an MA local area (as defined in paragraph (2)); and

(B) with respect to an MA regional plan, an MA region (as established under section 1395w-27a(a)(2) of this title).

(2) MA local area

The term “MA local area” means a county or equivalent area specified by the Secretary.

(3) Rule for ESRD beneficiaries

In the case of individuals who are determined to have end stage renal disease, the Medicare+Choice payment area shall be a State or such other payment area as the Secretary specifies.

(4) Geographic adjustment

(A) In general

Upon written request of the chief executive officer of a State for a contract year (beginning after 1998) made by not later than February 1 of the previous year, the Secretary shall make a geographic adjustment to a Medicare+Choice payment area in the State otherwise determined under paragraph (1) for MA local plans—

(i) to a single statewide Medicare+Choice payment area,

(ii) to the metropolitan based system described in subparagraph (C), or

(iii) to consolidating into a single Medicare+Choice payment area noncontiguous counties (or equivalent areas described in paragraph (1)(A)) within a State.

Such adjustment shall be effective for payments for months beginning with January of the year following the year in which the request is received.

(B) Budget neutrality adjustment

In the case of a State requesting an adjustment under this paragraph, the Secretary shall initially (and annually thereafter) adjust the payment rates otherwise established under this section with respect to MA local

plans for Medicare+Choice payment areas in the State in a manner so that the aggregate of the payments under this section for such plans in the State shall not exceed the aggregate payments that would have been made under this section for such plans for Medicare+Choice payment areas in the State in the absence of the adjustment under this paragraph.

(C) Metropolitan based system

The metropolitan based system described in this subparagraph is one in which—

(i) all the portions of each metropolitan statistical area in the State or in the case of a consolidated metropolitan statistical area, all of the portions of each primary metropolitan statistical area within the consolidated area within the State, are treated as a single Medicare+Choice payment area, and

(ii) all areas in the State that do not fall within a metropolitan statistical area are treated as a single Medicare+Choice payment area.

(D) Areas

In subparagraph (C), the terms “metropolitan statistical area”, “consolidated metropolitan statistical area”, and “primary metropolitan statistical area” mean any area designated as such by the Secretary of Commerce.

(e) Special rules for individuals electing MSA plans

(1) In general

If the amount of the Medicare+Choice monthly MSA premium (as defined in section 1395w-24(b)(2)(C) of this title) for an MSA plan for a year is less than $\frac{1}{12}$ of the annual Medicare+Choice capitation rate applied under this section for the area and year involved, the Secretary shall deposit an amount equal to 100 percent of such difference in a Medicare+Choice MSA established (and, if applicable, designated) by the individual under paragraph (2).

(2) Establishment and designation of Medicare+Choice medical savings account as requirement for payment of contribution

In the case of an individual who has elected coverage under an MSA plan, no payment shall be made under paragraph (1) on behalf of an individual for a month unless the individual—

(A) has established before the beginning of the month (or by such other deadline as the Secretary may specify) a Medicare+Choice MSA (as defined in section 138(b)(2) of the Internal Revenue Code of 1986), and

(B) if the individual has established more than one such Medicare+Choice MSA, has designated one of such accounts as the individual's Medicare+Choice MSA for purposes of this part.

Under rules under this section, such an individual may change the designation of such account under subparagraph (B) for purposes of this part.

(3) Lump-sum deposit of medical savings account contribution

In the case of an individual electing an MSA plan effective beginning with a month in a year, the amount of the contribution to the Medicare+Choice MSA on behalf of the individual for that month and all successive months in the year shall be deposited during that first month. In the case of a termination of such an election as of a month before the end of a year, the Secretary shall provide for a procedure for the recovery of deposits attributable to the remaining months in the year.

(f) Payments from Trust Funds

The payment to a Medicare+Choice organization under this section for individuals enrolled under this part with the organization and for payments under subsection (l) and subsection (m) and payments to a Medicare+Choice MSA under subsection (e)(1) of this section shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under part A of this subchapter and under part B of this subchapter represents of the actuarial value of the total benefits under this subchapter. Payments to MA organizations for statutory drug benefits provided under this subchapter are made from the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund. Monthly payments otherwise payable under this section for October 2000 shall be paid on the first business day of such month. Monthly payments otherwise payable under this section for October 2001 shall be paid on the last business day of September 2001. Monthly payments otherwise payable under this section for October 2006 shall be paid on the first business day of October 2006.

(g) Special rule for certain inpatient hospital stays

In the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1395ww(d)(1)(B) of this title), a rehabilitation hospital described in section 1395ww(d)(1)(B)(ii) of this title or a distinct part rehabilitation unit described in the matter following clause (v) of section 1395ww(d)(1)(B) of this title, or a long-term care hospital (described in section 1395ww(d)(1)(B)(iv) of this title) as of the effective date of the individual's—

(1) election under this part of a Medicare+Choice plan offered by a Medicare+Choice organization—

(A) payment for such services until the date of the individual's discharge shall be made under this subchapter through the Medicare+Choice plan or the original Medicare fee-for-service program option described in section 1395w-21(a)(1)(A) of this title (as the case may be) elected before the election with such organization,

(B) the elected organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

(C) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this part; or

(2) termination of election with respect to a Medicare+Choice organization under this part—

(A) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

(B) payment for such services during the stay shall not be made under section 1395ww(d) of this title or other payment provision under this subchapter for inpatient services for the type of facility, hospital, or unit involved, described in the matter preceding paragraph (1), as the case may be, or by any succeeding Medicare+Choice organization, and

(C) the terminated organization shall not receive any payment with respect to the individual under this part during the period the individual is not enrolled.

(h) Special rule for hospice care

(1) Information

A contract under this part shall require the Medicare+Choice organization to inform each individual enrolled under this part with a Medicare+Choice plan offered by the organization about the availability of hospice care if—

(A) a hospice program participating under this subchapter is located within the organization's service area; or

(B) it is common practice to refer patients to hospice programs outside such service area.

(2) Payment

If an individual who is enrolled with a Medicare+Choice organization under this part makes an election under section 1395d(d)(1) of this title to receive hospice care from a particular hospice program—

(A) payment for the hospice care furnished to the individual shall be made to the hospice program elected by the individual by the Secretary;

(B) payment for other services for which the individual is eligible notwithstanding the individual's election of hospice care under section 1395d(d)(1) of this title, including services not related to the individual's terminal illness, shall be made by the Secretary to the Medicare+Choice organization or the provider or supplier of the service instead of payments calculated under subsection (a) of this section; and

(C) the Secretary shall continue to make monthly payments to the Medicare+Choice organization in an amount equal to the value of the additional benefits required under section 1395w-24(f)(1)(A) of this title.

(i) New entry bonus

(1) In general

Subject to paragraphs (2) and (3), in the case of Medicare+Choice payment area in which a Medicare+Choice plan has not been offered since 1997 (or in which all organizations that offered a plan since such date have filed notice with the Secretary, as of October 13, 1999, that they will not be offering such a plan as of January 1, 2000, or filed notice with the Secretary

as of October 3, 2000, that they will not be offering such a plan as of January 1, 2001), the amount of the monthly payment otherwise made under this section shall be increased—

(A) only for the first 12 months in which any Medicare+Choice plan is offered in the area, by 5 percent of the total monthly payment otherwise computed for such payment area; and

(B) only for the subsequent 12 months, by 3 percent of the total monthly payment otherwise computed for such payment area.

(2) Period of application

Paragraph (1) shall only apply to payment for Medicare+Choice plans which are first offered in a Medicare+Choice payment area during the 2-year period beginning on January 1, 2000.

(3) Limitation to organization offering first plan in an area

Paragraph (1) shall only apply to payment to the first Medicare+Choice organization that offers a Medicare+Choice plan in each Medicare+Choice payment area, except that if more than one such organization first offers such a plan in an area on the same date, paragraph (1) shall apply to payment for such organizations.

(4) Construction

Nothing in paragraph (1) shall be construed as affecting the calculation of the annual Medicare+Choice capitation rate under subsection (c) of this section for any payment area or as applying to payment for any period not described in such paragraph and paragraph (2).

(5) Offered defined

In this subsection, the term “offered” means, with respect to a Medicare+Choice plan as of a date, that a Medicare+Choice eligible individual may enroll with the plan on that date, regardless of when the enrollment takes effect or when the individual obtains benefits under the plan.

(j) Computation of benchmark amounts

For purposes of this part, subject to subsection (o), the term “MA area-specific non-drug monthly benchmark amount” means for a month in a year—

(1) with respect to—

(A) a service area that is entirely within an MA local area, subject to section 1395w-29(d)(2)(A)² of this title, an amount equal to $\frac{1}{12}$ of the annual MA capitation rate under subsection (c)(1) for the area for the year (or, for 2007, 2008, 2009, and 2010, $\frac{1}{12}$ of the applicable amount determined under subsection (k)(1) for the area for the year; for 2011, $\frac{1}{12}$ of the applicable amount determined under subsection (k)(1) for the area for 2010; and, beginning with 2012, $\frac{1}{12}$ of the blended benchmark amount determined under subsection (n)(1) for the area for the year), adjusted as appropriate (for years before 2007) for the purpose of risk adjustment; or

(B) a service area that includes more than one MA local area, an amount equal to the

average of the amounts described in subparagraph (A) for each such local MA area, weighted by the projected number of enrollees in the plan residing in the respective local MA areas (as used by the plan for purposes of the bid and disclosed to the Secretary under section 1395w-24(a)(6)(A)(iii) of this title), adjusted as appropriate (for years before 2007) for the purpose of risk adjustment; or

(2) with respect to an MA region for a month in a year, the MA region-specific non-drug monthly benchmark amount, as defined in section 1395w-27a(f) of this title for the region for the year.

(k) Determination of applicable amount for purposes of calculating the benchmark amounts

(1) Applicable amount defined

For purposes of subsection (j), subject to paragraphs (2) and (4), the term “applicable amount” means for an area—

(A) for 2007—

(i) if such year is not specified under subsection (c)(1)(D)(ii), an amount equal to the amount specified in subsection (c)(1)(C) for the area for 2006—

(I) first adjusted by the rescaling factor for 2006 for the area (as made available by the Secretary in the announcement of the rates on April 4, 2005, under subsection (b)(1), but excluding any national adjustment factors for coding intensity and risk adjustment budget neutrality that were included in such factor); and

(II) then increased by the national per capita MA growth percentage, described in subsection (c)(6) for 2007, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004;

(ii) if such year is specified under subsection (c)(1)(D)(ii), an amount equal to the greater of—

(I) the amount determined under clause (i) for the area for the year; or

(II) the amount specified in subsection (c)(1)(D) for the area for the year; and

(B) for a subsequent year—

(i) if such year is not specified under subsection (c)(1)(D)(ii), an amount equal to the amount determined under this paragraph for the area for the previous year (determined without regard to paragraphs (2) and (4)), increased by the national per capita MA growth percentage, described in subsection (c)(6) for that succeeding year, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004; and

(ii) if such year is specified under subsection (c)(1)(D)(ii), an amount equal to the greater of—

(I) the amount determined under clause (i) for the area for the year; or

(II) the amount specified in subsection (c)(1)(D) for the area for the year.

(2) Phase-out of budget neutrality factor**(A) In general**

Except as provided in subparagraph (D), in the case of 2007 through 2010, the applicable amount determined under paragraph (1) shall be multiplied by a factor equal to 1 plus the product of—

- (i) the percent determined under subparagraph (B) for the year; and
- (ii) the applicable phase-out factor for the year under subparagraph (C).

(B) Percent determined**(i) In general**

For purposes of subparagraph (A)(i), subject to clause (iv), the percent determined under this subparagraph for a year is a percent equal to a fraction the numerator of which is described in clause (ii) and the denominator of which is described in clause (iii).

(ii) Numerator based on difference between demographic rate and risk rate**(I) In general**

The numerator described in this clause is an amount equal to the amount by which the demographic rate described in subclause (II) exceeds the risk rate described in subclause (III).

(II) Demographic rate

The demographic rate described in this subclause is the Secretary's estimate of the total payments that would have been made under this part in the year if all the monthly payment amounts for all MA plans were equal to $\frac{1}{2}$ of the annual MA capitation rate under subsection (c)(1) for the area and year, adjusted pursuant to subsection (a)(1)(C).

(III) Risk rate

The risk rate described in this subclause is the Secretary's estimate of the total payments that would have been made under this part in the year if all the monthly payment amounts for all MA plans were equal to the amount described in subsection (j)(1)(A) (determined as if this paragraph had not applied) under subsection (j) for the area and year, adjusted pursuant to subsection (a)(1)(C).

(iii) Denominator based on risk rate

The denominator described in this clause is equal to the total amount estimated for the year under clause (ii)(III).

(iv) Requirements

In estimating the amounts under the previous clauses, the Secretary shall—

- (I) use a complete set of the most recent and representative Medicare Advantage risk scores under subsection (a)(3) that are available from the risk adjustment model announced for the year;
- (II) adjust the risk scores to reflect changes in treatment and coding practices in the fee-for-service sector;
- (III) adjust the risk scores for differences in coding patterns between

Medicare Advantage plans and providers under the original Medicare fee-for-service program under parts A and B to the extent that the Secretary has identified such differences, as required in subsection (a)(1)(C);

(IV) as necessary, adjust the risk scores for late data submitted by Medicare Advantage organizations;

(V) as necessary, adjust the risk scores for lagged cohorts; and

(VI) as necessary, adjust the risk scores for changes in enrollment in Medicare Advantage plans during the year.

(v) Authority

In computing such amounts the Secretary may take into account the estimated health risk of enrollees in preferred provider organization plans (including MA regional plans) for the year.

(C) Applicable phase-out factor

For purposes of subparagraph (A)(ii), the term “applicable phase-out factor” means—

- (i) for 2007, 0.55;
- (ii) for 2008, 0.40;
- (iii) for 2009, 0.25; and
- (iv) for 2010, 0.05.

(D) Termination of application

Subparagraph (A) shall not apply in a year if the amount estimated under subparagraph (B)(ii)(III) for the year is equal to or greater than the amount estimated under subparagraph (B)(ii)(II) for the year.

(3) No revision in percent**(A) In general**

The Secretary may not make any adjustment to the percent determined under paragraph (2)(B) for any year.

(B) Rule of construction

Nothing in this subsection shall be construed to limit the authority of the Secretary to make adjustments to the applicable amounts determined under paragraph (1) as appropriate for purposes of updating data or for purposes of adopting an improved risk adjustment methodology.

(4) Phase-out of the indirect costs of medical education from capitation rates**(A) In general**

After determining the applicable amount for an area for a year under paragraph (1) (beginning with 2010), the Secretary shall adjust such applicable amount to exclude from such applicable amount the phase-in percentage (as defined in subparagraph (B)(i)) for the year of the Secretary's estimate of the standardized costs for payments under section 1395ww(d)(5)(B) of this title in the area for the year. Any adjustment under the preceding sentence shall be made prior to the application of paragraph (2).

(B) Percentages defined

For purposes of this paragraph:

(i) Phase-in percentage

The term “phase-in percentage” means, for an area for a year, the ratio (expressed

as a percentage, but in no case greater than 100 percent) of—

(I) the maximum cumulative adjustment percentage for the year (as defined in clause (ii)); to

(II) the standardized IME cost percentage (as defined in clause (iii)) for the area and year.

(ii) Maximum cumulative adjustment percentage

The term “maximum cumulative adjustment percentage” means, for—

(I) 2010, 0.60 percent; and

(II) a subsequent year, the maximum cumulative adjustment percentage for the previous year increased by 0.60 percentage points.

(iii) Standardized IME cost percentage

The term “standardized IME cost percentage” means, for an area for a year, the per capita costs for payments under section 1395ww(d)(5)(B) of this title (expressed as a percentage of the fee-for-service amount specified in subparagraph (C)) for the area and the year.

(C) Fee-for-service amount

The fee-for-service amount specified in this subparagraph for an area for a year is the amount specified under subsection (c)(1)(D) for the area and the year.

(I) Application of eligible professional incentives for certain MA organizations for adoption and meaningful use of certified EHR technology

(1) In general

Subject to paragraphs (3) and (4), in the case of a qualifying MA organization, the provisions of sections 1395w-4(o) and 1395w-4(a)(7) of this title shall apply with respect to eligible professionals described in paragraph (2) of the organization who the organization attests under paragraph (6) to be meaningful EHR users in a similar manner as they apply to eligible professionals under such sections. Incentive payments under paragraph (3) shall be made to and payment adjustments under paragraph (4) shall apply to such qualifying organizations.

(2) Eligible professional described

With respect to a qualifying MA organization, an eligible professional described in this paragraph is an eligible professional (as defined for purposes of section 1395w-4(o) of this title) who—

(A)(i) is employed by the organization; or

(ii)(I) is employed by, or is a partner of, an entity that through contract with the organization furnishes at least 80 percent of the entity's Medicare patient care services to enrollees of such organization; and

(II) furnishes at least 80 percent of the professional services of the eligible professional covered under this subchapter to enrollees of the organization; and

(B) furnishes, on average, at least 20 hours per week of patient care services.

(3) Eligible professional incentive payments

(A) In general

In applying section 1395w-4(o) of this title under paragraph (1), instead of the additional payment amount under section 1395w-4(o)(1)(A) of this title and subject to subparagraph (B), the Secretary may substitute an amount determined by the Secretary to the extent feasible and practical to be similar to the estimated amount in the aggregate that would be payable if payment for services furnished by such professionals was payable under part B instead of this part.

(B) Avoiding duplication of payments

(i) In general

In the case of an eligible professional described in paragraph (2)—

(I) that is eligible for the maximum incentive payment under section 1395w-4(o)(1)(A) of this title for the same payment period, the payment incentive shall be made only under such section and not under this subsection; and

(II) that is eligible for less than such maximum incentive payment for the same payment period, the payment incentive shall be made only under this subsection and not under section 1395w-4(o)(1)(A) of this title.

(ii) Methods

In the case of an eligible professional described in paragraph (2) who is eligible for an incentive payment under section 1395w-4(o)(1)(A) of this title but is not described in clause (i) for the same payment period, the Secretary shall develop a process—

(I) to ensure that duplicate payments are not made with respect to an eligible professional both under this subsection and under section 1395w-4(o)(1)(A) of this title; and

(II) to collect data from Medicare Advantage organizations to ensure against such duplicate payments.

(C) Fixed schedule for application of limitation on incentive payments for all eligible professionals

In applying section 1395w-4(o)(1)(B)(ii) of this title under subparagraph (A), in accordance with rules specified by the Secretary, a qualifying MA organization shall specify a year (not earlier than 2011) that shall be treated as the first payment year for all eligible professionals with respect to such organization.

(4) Payment adjustment

(A) In general

In applying section 1395w-4(a)(7) of this title under paragraph (1), instead of the payment adjustment being an applicable percent of the fee schedule amount for a year under such section, subject to subparagraph (D), the payment adjustment under paragraph (1) shall be equal to the percent specified in subparagraph (B) for such year of the

payment amount otherwise provided under this section for such year.

(B) Specified percent

The percent specified under this subparagraph for a year is 100 percent minus a number of percentage points equal to the product of—

- (i) the number of percentage points by which the applicable percent (under section 1395w-4(a)(7)(A)(ii) of this title) for the year is less than 100 percent; and
- (ii) the Medicare physician expenditure proportion specified in subparagraph (C) for the year.

(C) Medicare physician expenditure proportion

The Medicare physician expenditure proportion under this subparagraph for a year is the Secretary's estimate of the proportion, of the expenditures under parts A and B that are not attributable to this part, that are attributable to expenditures for physicians' services.

(D) Application of payment adjustment

In the case that a qualifying MA organization attests that not all eligible professionals of the organization are meaningful EHR users with respect to a year, the Secretary shall apply the payment adjustment under this paragraph based on the proportion of all such eligible professionals of the organization that are not meaningful EHR users for such year.

(5) Qualifying MA organization defined

In this subsection and subsection (m), the term "qualifying MA organization" means a Medicare Advantage organization that is organized as a health maintenance organization (as defined in section 300gg-91(b)(3) of this title).

(6) Meaningful EHR user attestation

For purposes of this subsection and subsection (m), a qualifying MA organization shall submit an attestation, in a form and manner specified by the Secretary which may include the submission of such attestation as part of submission of the initial bid under section 1395w-24(a)(1)(A)(iv)⁴ of this title, identifying—

- (A) whether each eligible professional described in paragraph (2), with respect to such organization is a meaningful EHR user (as defined in section 1395w-4(o)(2) of this title) for a year specified by the Secretary; and
- (B) whether each eligible hospital described in subsection (m)(1),⁵ with respect to such organization, is a meaningful EHR user (as defined in section 1395ww(n)(3) of this title) for an applicable period specified by the Secretary.

(7) Posting on website

The Secretary shall post on the Internet website of the Centers for Medicare & Medic-

aid Services, in an easily understandable format, a list of the names, business addresses, and business phone numbers of—

- (A) each qualifying MA organization receiving an incentive payment under this subsection for eligible professionals of the organization; and
- (B) the eligible professionals of such organization for which such incentive payment is based.

(8) Limitation on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise, of—

- (A) the methodology and standards for determining payment amounts and payment adjustments under this subsection, including avoiding duplication of payments under paragraph (3)(B) and the specification of rules for the fixed schedule for application of limitation on incentive payments for all eligible professionals under paragraph (3)(C);

- (B) the methodology and standards for determining eligible professionals under paragraph (2); and

- (C) the methodology and standards for determining a meaningful EHR user under section 1395w-4(o)(2) of this title, including specification of the means of demonstrating meaningful EHR use under section 1395w-4(o)(3)(C)⁶ of this title and selection of measures under section 1395w-4(o)(3)(B)⁷ of this title.

(m) Application of eligible hospital incentives for certain MA organizations for adoption and meaningful use of certified EHR technology

(1) Application

Subject to paragraphs (3) and (4), in the case of a qualifying MA organization, the provisions of sections 1395ww(n) and 1395ww(b)(3)(B)(ix) of this title shall apply with respect to eligible hospitals described in paragraph (2) of the organization which the organization attests under subsection (l)(6) to be meaningful EHR users in a similar manner as they apply to eligible hospitals under such sections. Incentive payments under paragraph (3) shall be made to and payment adjustments under paragraph (4) shall apply to such qualifying organizations.

(2) Eligible hospital described

With respect to a qualifying MA organization, an eligible hospital described in this paragraph is an eligible hospital (as defined in section 1395ww(n)(6)(B) of this title) that is under common corporate governance with such organization and serves individuals enrolled under an MA plan offered by such organization.

(3) Eligible hospital incentive payments

(A) In general

In applying section 1395ww(n)(2) of this title under paragraph (1), instead of the additional payment amount under section 1395ww(n)(2) of this title, there shall be sub-

⁴ So in original. Section 1395w-24(a)(1)(A) of this title does not contain a cl. (iv).

⁵ So in original. Probably should be "(m)(2)".

⁶ So in original. Probably should be "1395w-4(o)(2)(C)".

⁷ So in original. Probably should be "1395w-4(o)(2)(B)".

stituted an amount determined by the Secretary to be similar to the estimated amount in the aggregate that would be payable if payment for services furnished by such hospitals was payable under part A instead of this part. In implementing the previous sentence, the Secretary—

(i) shall, insofar as data to determine the discharge related amount under section 1395ww(n)(2)(C) of this title for an eligible hospital are not available to the Secretary, use such alternative data and methodology to estimate such discharge related amount as the Secretary determines appropriate; and

(ii) shall, insofar as data to determine the medicare share described in section 1395ww(n)(2)(D) of this title for an eligible hospital are not available to the Secretary, use such alternative data and methodology to estimate such share, which data and methodology may include use of the inpatient-bed-days (or discharges) with respect to an eligible hospital during the appropriate period which are attributable to both individuals for whom payment may be made under part A or individuals enrolled in an MA plan under a Medicare Advantage organization under this part as a proportion of the estimated total number of patient-bed-days (or discharges) with respect to such hospital during such period.

(B) Avoiding duplication of payments

(i) In general

In the case of a hospital that for a payment year is an eligible hospital described in paragraph (2) and for which at least one-third of their discharges (or bed-days) of Medicare patients for the year are covered under part A, payment for the payment year shall be made only under section 1395ww(n) of this title and not under this subsection.

(ii) Methods

In the case of a hospital that is an eligible hospital described in paragraph (2) and also is eligible for an incentive payment under section 1395ww(n) of this title but is not described in clause (i) for the same payment period, the Secretary shall develop a process—

(I) to ensure that duplicate payments are not made with respect to an eligible hospital both under this subsection and under section 1395ww(n) of this title; and

(II) to collect data from Medicare Advantage organizations to ensure against such duplicate payments.

(4) Payment adjustment

(A) Subject to paragraph (3), in the case of a qualifying MA organization (as defined in subsection (l)(5)), if, according to the attestation of the organization submitted under subsection (l)(6) for an applicable period, one or more eligible hospitals (as defined in section 1395ww(n)(6)(B) of this title) that are under common corporate governance with such organization and that serve individuals enrolled

under a plan offered by such organization are not meaningful EHR users (as defined in section 1395ww(n)(3) of this title) with respect to a period, the payment amount payable under this section for such organization for such period shall be the percent specified in subparagraph (B) for such period of the payment amount otherwise provided under this section for such period.

(B) SPECIFIED PERCENT.—The percent specified under this subparagraph for a year is 100 percent minus a number of percentage points equal to the product of—

(i) the number of the percentage point reduction effected under section 1395ww(b)(3)(B)(ix)(I) of this title for the period; and

(ii) the Medicare hospital expenditure proportion specified in subparagraph (C) for the year.

(C) MEDICARE HOSPITAL EXPENDITURE PROPORTION.—The Medicare hospital expenditure proportion under this subparagraph for a year is the Secretary's estimate of the proportion, of the expenditures under parts A and B that are not attributable to this part, that are attributable to expenditures for inpatient hospital services.

(D) APPLICATION OF PAYMENT ADJUSTMENT.—In the case that a qualifying MA organization attests that not all eligible hospitals are meaningful EHR users with respect to an applicable period, the Secretary shall apply the payment adjustment under this paragraph based on a methodology specified by the Secretary, taking into account the proportion of such eligible hospitals, or discharges from such hospitals, that are not meaningful EHR users for such period.

(5) Posting on website

The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format—

(A) a list of the names, business addresses, and business phone numbers of each qualifying MA organization receiving an incentive payment under this subsection for eligible hospitals described in paragraph (2); and

(B) a list of the names of the eligible hospitals for which such incentive payment is based.

(6) Limitations on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise, of—

(A) the methodology and standards for determining payment amounts and payment adjustments under this subsection, including avoiding duplication of payments under paragraph (3)(B);

(B) the methodology and standards for determining eligible hospitals under paragraph (2); and

(C) the methodology and standards for determining a meaningful EHR user under section 1395ww(n)(3) of this title, including specification of the means of demonstrating meaningful EHR use under subparagraph (C)

of such section and selection of measures under subparagraph (B) of such section.

(n) Determination of blended benchmark amount

(1) In general

For purposes of subsection (j), subject to paragraphs (3), (4), and (5), the term “blended benchmark amount” means for an area—

(A) for 2012 the sum of—

- (i) $\frac{1}{2}$ of the applicable amount for the area and year; and
- (ii) $\frac{1}{2}$ of the amount specified in paragraph (2)(A) for the area and year; and

(B) for a subsequent year the amount specified in paragraph (2)(A) for the area and year.

(2) Specified amount

(A) In general

The amount specified in this subparagraph for an area and year is the product of—

- (i) the base payment amount specified in subparagraph (E) for the area and year adjusted to take into account the phase-out in the indirect costs of medical education from capitation rates described in subsection (k)(4); and
- (ii) the applicable percentage for the area for the year specified under subparagraph (B).

(B) Applicable percentage

Subject to subparagraph (D), the applicable percentage specified in this subparagraph for an area for a year in the case of an area that is ranked—

- (i) in the highest quartile under subparagraph (C) for the previous year is 95 percent;
- (ii) in the second highest quartile under such subparagraph for the previous year is 100 percent;
- (iii) in the third highest quartile under such subparagraph for the previous year is 107.5 percent; or
- (iv) in the lowest quartile under such subparagraph for the previous year is 115 percent.

(C) Periodic ranking

For purposes of this paragraph in the case of an area located—

- (i) in 1 of the 50 States or the District of Columbia, the Secretary shall rank such area in each year specified under subsection (c)(1)(D)(ii) based upon the level of the amount specified in subparagraph (A)(i) for such areas; or
- (ii) in a territory, the Secretary shall rank such areas in each such year based upon the level of the amount specified in subparagraph (A)(i) for such area relative to quartile rankings computed under clause (i).

(D) 1-year transition for changes in applicable percentage

If, for a year after 2012, there is a change in the quartile in which an area is ranked compared to the previous year, the applicable percentage for the area in the year shall be the average of—

- (i) the applicable percentage for the area for the previous year; and
- (ii) the applicable percentage that would otherwise apply for the area for the year.

(E) Base payment amount

Subject to subparagraph (F), the base payment amount specified in this subparagraph—

- (i) for 2012 is the amount specified in subsection (c)(1)(D) for the area for the year; or
- (ii) for a subsequent year that—
 - (I) is not specified under subsection (c)(1)(D)(ii), is the base amount specified in this subparagraph for the area for the previous year, increased by the national per capita MA growth percentage, described in subsection (c)(6) for that succeeding year, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004; and
 - (II) is specified under subsection (c)(1)(D)(ii), is the amount specified in subsection (c)(1)(D) for the area for the year.

(F) Application of indirect medical education phase-out

The base payment amount specified in subparagraph (E) for a year shall be adjusted in the same manner under paragraph (4) of subsection (k) as the applicable amount is adjusted under such subsection.

(3) Alternative phase-ins

(A) 4-year phase-in for certain areas

If the difference between the applicable amount (as defined in subsection (k)) for an area for 2010 and the projected 2010 benchmark amount (as defined in subparagraph (C)) for the area is at least \$30 but less than \$50, the blended benchmark amount for the area is—

- (i) for 2012 the sum of—
 - (I) $\frac{3}{4}$ of the applicable amount for the area and year; and
 - (II) $\frac{1}{4}$ of the amount specified in paragraph (2)(A) for the area and year;
- (ii) for 2013 the sum of—
 - (I) $\frac{1}{2}$ of the applicable amount for the area and year; and
 - (II) $\frac{1}{2}$ of the amount specified in paragraph (2)(A) for the area and year;
- (iii) for 2014 the sum of—
 - (I) $\frac{1}{4}$ of the applicable amount for the area and year; and
 - (II) $\frac{3}{4}$ of the amount specified in paragraph (2)(A) for the area and year; and
- (iv) for a subsequent year the amount specified in paragraph (2)(A) for the area and year.

(B) 6-year phase-in for certain areas

If the difference between the applicable amount (as defined in subsection (k)) for an area for 2010 and the projected 2010 benchmark amount (as defined in subparagraph (C)) for the area is at least \$50, the blended benchmark amount for the area is—

- (i) for 2012 the sum of—
 - (I) $\frac{5}{6}$ of the applicable amount for the area and year; and
 - (II) $\frac{1}{6}$ of the amount specified in paragraph (2)(A) for the area and year;
- (ii) for 2013 the sum of—
 - (I) $\frac{2}{3}$ of the applicable amount for the area and year; and
 - (II) $\frac{1}{3}$ of the amount specified in paragraph (2)(A) for the area and year;
- (iii) for 2014 the sum of—
 - (I) $\frac{1}{2}$ of the applicable amount for the area and year; and
 - (II) $\frac{1}{2}$ of the amount specified in paragraph (2)(A) for the area and year;
- (iv) for 2015 the sum of—
 - (I) $\frac{1}{3}$ of the applicable amount for the area and year; and
 - (II) $\frac{2}{3}$ of the amount specified in paragraph (2)(A) for the area and year; and
- (v) for 2016 the sum of—
 - (I) $\frac{1}{6}$ of the applicable amount for the area and year; and
 - (II) $\frac{5}{6}$ of the amount specified in paragraph (2)(A) for the area and year; and
- (vi) for a subsequent year the amount specified in paragraph (2)(A) for the area and year.

(C) Projected 2010 benchmark amount

The projected 2010 benchmark amount described in this subparagraph for an area is equal to the sum of—

- (i) $\frac{1}{2}$ of the applicable amount (as defined in subsection (k)) for the area for 2010; and
- (ii) $\frac{1}{2}$ of the amount specified in paragraph (2)(A) for the area for 2010 but determined as if there were substituted for the applicable percentage specified in clause (ii) of such paragraph the sum of—
 - (I) the applicable percent that would be specified under subparagraph (B) of paragraph (2) (determined without regard to subparagraph (D) of such paragraph) for the area for 2010 if any reference in such paragraph to “the previous year” were deemed a reference to 2010; and
 - (II) the applicable percentage increase that would apply to a qualifying plan in the area under subsection (o) as if any reference in such subsection to 2012 were deemed a reference to 2010 and as if the determination of a qualifying county under paragraph (3)(B) of such subsection were made for 2010.

(4) Cap on benchmark amount

In no case shall the blended benchmark amount for an area for a year (determined taking into account subsection (o)) be greater than the applicable amount that would (but for the application of this subsection) be determined under subsection (k)(1) for the area for the year.

(5) Non-application to PACE plans

This subsection shall not apply to payments to a PACE program under section 1395eee of this title.

(o) Applicable percentage quality increases

(1) In general

Subject to the succeeding paragraphs, in the case of a qualifying plan with respect to a year beginning with 2012, the applicable percentage under subsection (n)(2)(B) shall be increased on a plan or contract level, as determined by the Secretary—

- (A) for 2012, by 1.5 percentage points;
- (B) for 2013, by 3.0 percentage points; and
- (C) for 2014 or a subsequent year, by 5.0 percentage points.

(2) Increase for qualifying plans in qualifying counties

The increase applied under paragraph (1) for a qualifying plan located in a qualifying county for a year shall be doubled.

(3) Qualifying plans and qualifying county defined; application of increases to low enrollment and new plans

For purposes of this subsection:

(A) Qualifying plan

(i) In general

The term “qualifying plan” means, for a year and subject to paragraph (4), a plan that had a quality rating under paragraph (4) of 4 stars or higher based on the most recent data available for such year.

(ii) Application of increases to low enrollment plans

(I) 2012

For 2012, the term “qualifying plan” includes an MA plan that the Secretary determines is not able to have a quality rating under paragraph (4) because of low enrollment.

(II) 2013 and subsequent years

For 2013 and subsequent years, for purposes of determining whether an MA plan with low enrollment (as defined by the Secretary) is included as a qualifying plan, the Secretary shall establish a method to apply to MA plans with low enrollment (as defined by the Secretary) the computation of quality rating and the rating system under paragraph (4).

(iii) Application of increases to new plans

(I) In general

A new MA plan that meets criteria specified by the Secretary shall be treated as a qualifying plan, except that in applying paragraph (1), the applicable percentage under subsection (n)(2)(B) shall be increased—

- (aa) for 2012, by 1.5 percentage points;
- (bb) for 2013, by 2.5 percentage points; and
- (cc) for 2014 or a subsequent year, by 3.5 percentage points.

(II) New MA plan defined

The term “new MA plan” means, with respect to a year, a plan offered by an organization or sponsor that has not had a contract as a Medicare Advantage organization in the preceding 3-year period.

(B) Qualifying county

The term “qualifying county” means, for a year, a county—

(i) that has an MA capitation rate that, in 2004, was based on the amount specified in subsection (c)(1)(B) for a Metropolitan Statistical Area with a population of more than 250,000;

(ii) for which, as of December 2009, of the Medicare Advantage eligible individuals residing in the county at least 25 percent of such individuals were enrolled in Medicare Advantage plans; and

(iii) that has per capita fee-for-service spending that is lower than the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year.

(4) Quality determinations for application of increase**(A) Quality determination**

The quality rating for a plan shall be determined according to a 5-star rating system (based on the data collected under section 1395w-22(e) of this title).

(B) Plans that failed to report

An MA plan which does not report data that enables the Secretary to rate the plan for purposes of this paragraph shall be counted as having a rating of fewer than 3.5 stars.

(C) Special rule for first 3 plan years for plans that were converted from a reasonable cost reimbursement contract

For purposes of applying paragraph (1) and section 1395w-24(b)(1)(C) of this title for the first 3 plan years under this part in the case of an MA plan to which deemed enrollment applies under section 1395w-21(c)(4) of this title—

(i) such plan shall not be treated as a new MA plan (as defined in paragraph (3)(A)(iii)(II)); and

(ii) in determining the star rating of the plan under subparagraph (A), to the extent that Medicare Advantage data for such plan is not available for a measure used to determine such star rating, the Secretary shall use data from the period in which such plan was a reasonable cost reimbursement contract.

(5) Exception for PACE plans

This subsection shall not apply to payments to a PACE program under section 1395eee of this title.

(Aug. 14, 1935, ch. 531, title XVIII, § 1853, as added Pub. L. 105-33, title IV, § 4001, Aug. 5, 1997, 111 Stat. 299; amended Pub. L. 106-113, div. B, § 1000(a)(6) [title V, §§ 511(a), 512, 514(a), 517], Nov. 29, 1999, 113 Stat. 1536, 1501A-380, 1501A-382 to 1501A-384; Pub. L. 106-554, § 1(a)(6) [title VI, §§ 601(a), 602(a), 603, 605(a), 606(a)(2)(A), 607, 608(a), 611(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A-554 to 2763A-559; Pub. L. 107-188, title V, § 532(d)(1), June 12, 2002, 116 Stat. 696; Pub. L. 108-173, title I, § 101(e)(3)(D), title II, §§ 211(a)-(e)(1), 221(d)(1),

(4), 222(d)-(f), (i), 237(b)(1), (2)(B), 241(b)(1), title VII, § 736(d)(1), title IX, § 900(e)(1)(G), Dec. 8, 2003, 117 Stat. 2151, 2176-2178, 2192, 2193, 2200-2202, 2204, 2212, 2213, 2220, 2357, 2371; Pub. L. 109-171, title V, § 5301, Feb. 8, 2006, 120 Stat. 48; Pub. L. 110-275, title I, § 161(a), (b), July 15, 2008, 122 Stat. 2568, 2569; Pub. L. 111-5, div. B, title IV, §§ 4101(c), (e), 4102(c), (d)(3), Feb. 17, 2009, 123 Stat. 473, 476, 484, 486; Pub. L. 111-148, title III, §§ 3201(a)(1), (2)(A), (b), (e)(1), (2)(A)(ii)-(iv), (f)(1), (g), (h), (i)(2), 3202(b)(2), 3203, 3205(b), (f), title X, § 10318, Mar. 23, 2010, 124 Stat. 442, 444-447, 450, 452, 454-458, 948; Pub. L. 111-152, title I, § 1102(a)-(c)(3), (e), Mar. 30, 2010, 124 Stat. 1040, 1043, 1046; Pub. L. 112-240, title VI, § 639, Jan. 2, 2013, 126 Stat. 2357; Pub. L. 114-10, title II, § 209(d), Apr. 16, 2015, 129 Stat. 150; Pub. L. 114-106, § 2, Dec. 18, 2015, 129 Stat. 2222; Pub. L. 114-113, div. O, title VI, § 602(b)(2), Dec. 18, 2015, 129 Stat. 3024.)

REFERENCES IN TEXT

Subsection (b)(6)(B)(iii), referred to in subsec. (a)(1)(C)(iii)(II), probably means section 1395w-28(b)(6)(B)(iii) of this title. This section does not contain a subsec. (b)(6)(B)(iii).

Section 1395w-24(b)(1)(C)(iv) of this title, referred to in subsec. (a)(1)(E), was redesignated section 1395w-24(b)(1)(C)(v) of this title by Pub. L. 111-148, title III, § 3202(b)(1)(B), Mar. 23, 2010, 124 Stat. 454, and subsequently redesignated section 1395w-24(b)(1)(C)(viii) of this title by Pub. L. 111-152, title I, § 1102(d)(2), Mar. 30, 2010, 124 Stat. 1045.

Section 2355 of the Deficit Reduction Act of 1984, as amended by section 13567(b) of the Omnibus Budget Reconciliation Act of 1993, referred to in subsec. (a)(1)(H), is section 2355 of Pub. L. 98-369, div. B, title III, July 18, 1984, 98 Stat. 1103, as amended by section 13567(b) of Pub. L. 103-66, title XIII, Aug. 10, 1993, 107 Stat. 608, which is not classified to the Code.

Section 1395w-29 of this title, referred to in subsecs. (b)(1)(B)(iii) and (j)(1)(A), was repealed by Pub. L. 111-152, title I, § 1102(f), Mar. 30, 2010, 124 Stat. 1046.

The Internal Revenue Code of 1986, referred to in subsec. (e)(2)(A), is classified generally to Title 26, Internal Revenue Code.

AMENDMENTS

2015—Subsec. (b)(2). Pub. L. 114-106 inserted “(or, in 2017 and each subsequent year, at least 60 days)” after “45 days” and “(in 2017 and each subsequent year, of no less than 30 days)” after “opportunity”.

Subsec. (m)(2), (4)(A). Pub. L. 114-113 substituted “1395ww(n)(6)(B)” for “1395ww(n)(6)(A)”.

Subsec. (o)(4)(C). Pub. L. 114-10 added subpar. (C).

2013—Subsec. (a)(1)(C)(ii)(III). Pub. L. 112-240 substituted “1.5 percentage points” for “1.3 percentage points” and “5.9 percent” for “5.7 percent”.

2010—Subsec. (a)(1)(B)(i), (ii). Pub. L. 111-148, § 3201(f)(1)(B), which directed amendment of subpar. (B) by inserting “and any performance bonus under subsection (n)” before period at end of cl. (i) and substituting “(G), plus the amount (if any) of any performance bonus under subsection (n)” for “(G)” in cl. (ii), was repealed by Pub. L. 111-152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (a)(1)(B)(iv). Pub. L. 111-148, § 3205(b), added cl. (iv).

Subsec. (a)(1)(C)(ii). Pub. L. 111-152, § 1102(e)(2), substituted “and each subsequent year” for “through 2010” in introductory provisions.

Pub. L. 111-152, § 1102(e)(1), which directed the substitution of “of coding adjustment” for “during phaseout of budget neutrality factor” in heading, was executed by making the substitution for “during phase-out of budget neutrality factor” to reflect the probable intent of Congress.

Subsec. (a)(1)(C)(ii)(II). Pub. L. 111-152, § 1102(e)(3)(A)-(C), inserted “annually” before “conduct

an analysis” and “on a timely basis” after “are incorporated”, substituted “for 2008 and subsequent years” for “only for 2008, 2009, and 2010”, and inserted “and updated as appropriate” after “as available”.

Subsec. (a)(1)(C)(ii)(III), (IV). Pub. L. 111-152, § 1102(e)(3)(D), which directed amendment “in subclause (II)” of subsec. (a)(1)(C)(ii) by adding subcls. (III) and (IV) at the end, was executed by adding subcls. (III) and (IV) after subcl. (II), to reflect the probable intent of Congress.

Subsec. (a)(1)(C)(iii). Pub. L. 111-148, § 3205(f), added cl. (iii).

Pub. L. 111-148, § 3203, which directed amendment of subpar. (C) by adding cl. (iii) relating to application of coding intensity adjustment for 2011 and subsequent years, was repealed by Pub. L. 111-152, § 1102(a). As enacted, text read as follows:

“(I) REQUIREMENT TO APPLY IN 2011 THROUGH 2013.—In order to ensure payment accuracy, the Secretary shall conduct an analysis of the differences described in clause (ii)(I). The Secretary shall ensure that the results of such analysis are incorporated into the risk scores for 2011, 2012, and 2013.

“(II) AUTHORITY TO APPLY IN 2014 AND SUBSEQUENT YEARS.—The Secretary may, as appropriate, incorporate the results of such analysis into the risk scores for 2014 and subsequent years.”

See Effective Date of 2010 Amendment note below.

Subsec. (b)(1)(B)(i). Pub. L. 111-148, § 3201(e)(2)(A)(ii), which directed amendment of cl. (i) by substituting “MA local area (as defined in subsection (d)(2))” for “MA payment area” in introductory provisions and “MA local area (as so defined)” for “MA payment area” in subcl. (I), was repealed by Pub. L. 111-152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (b)(4). Pub. L. 111-148, § 3201(e)(2)(A)(iii), which directed substitution of “MA local area (as so defined)” for “Medicare Advantage payment area”, was repealed by Pub. L. 111-152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (c)(1). Pub. L. 111-148, § 3201(e)(2)(A)(iv), which directed amendment of par. (1) by striking “a Medicare Advantage payment area that is” in introductory provisions and substituting “MA local area (as defined in subsection (d)(2))” for “MA payment area” in subpar. (D)(i), was repealed by Pub. L. 111-152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (c)(6). Pub. L. 111-148, § 3201(b), which directed amendment of par. (6) by substituting “for 2003 through 2010” for “for a year after 2002” in cl. (vi) and adding cl. (vii), which read “for 2011, 3 percentage points; and”, and cl. (viii), which read “for a year after 2011, 0 percentage points.”, was repealed by Pub. L. 111-152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (d). Pub. L. 111-148, § 3201(e)(1)(A), which directed substitution of “MA region; MA local plan service area” for “MA region” in heading, was repealed by Pub. L. 111-152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (d)(1)(A). Pub. L. 111-148, § 3201(e)(1)(B), which directed substitution of “with respect to an MA local plan—

“(i) for years before 2012, an MA local area (as defined in paragraph (2)); and

“(ii) for 2012 and succeeding years, a service area that is an entire urban or rural area, as applicable (as described in paragraph (5)); and”

for “with respect to an MA local plan, an MA local area (as defined in paragraph (2)); and”, was repealed by Pub. L. 111-152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (d)(5). Pub. L. 111-148, § 3201(e)(1)(C), which directed the addition of par. (5), was repealed by Pub. L. 111-152, § 1102(a). As enacted, text read as follows: “For 2012 and succeeding years, the service area for an MA local plan shall be an entire urban or rural area in each State as follows:

“(A) URBAN AREAS.—

“(i) IN GENERAL.—Subject to clause (ii) and subparagraphs (C) and (D), the service area for an MA

local plan in an urban area shall be the Core Based Statistical Area (in this paragraph referred to as a ‘CBSA’) or, if applicable, a conceptually similar alternative classification, as defined by the Director of the Office of Management and Budget.

“(ii) CBSA COVERING MORE THAN ONE STATE.—In the case of a CBSA (or alternative classification) that covers more than one State, the Secretary shall divide the CBSA (or alternative classification) into separate service areas with respect to each State covered by the CBSA (or alternative classification).

“(B) RURAL AREAS.—Subject to subparagraphs (C) and (D), the service area for an MA local plan in a rural area shall be a county that does not qualify for inclusion in a CBSA (or alternative classification), as defined by the Director of the Office of Management and Budget.

“(C) REFINEMENTS TO SERVICE AREAS.—For 2015 and succeeding years, in order to reflect actual patterns of health care service utilization, the Secretary may adjust the boundaries of service areas for MA local plans in urban areas and rural areas under subparagraphs (A) and (B), respectively, but may only do so based on recent analyses of actual patterns of care.

“(D) ADDITIONAL AUTHORITY TO MAKE LIMITED EXCEPTIONS TO SERVICE AREA REQUIREMENTS FOR MA LOCAL PLANS.—The Secretary may, in addition to any adjustments under subparagraph (C), make limited exceptions to service area requirements otherwise applicable under this part for MA local plans that have in effect (as of March 23, 2010)—

“(i) agreements with another MA organization or MA plan that preclude the offering of benefits throughout an entire service area; or

“(ii) limitations in their structural capacity to support adequate networks throughout an entire service area as a result of the delivery system model of the MA local plan.”

See Effective Date of 2010 Amendment note below.

Subsec. (d)(6). Pub. L. 111-148, § 3201(i)(2), which directed the addition of par. (6), was repealed by Pub. L. 111-152, § 1102(a). As enacted, text read as follows: “For years beginning with 2012, in the case of a PACE program under section 1395eee of this title, the MA payment area shall be the MA local area (as defined in paragraph (2)).” See Effective Date of 2010 Amendment note below.

Subsec. (j). Pub. L. 111-152, § 1102(c)(1), inserted “subject to subsection (o),” after “For purposes of this part,” in introductory provisions.

Pub. L. 111-148, § 3201(a)(1)(A)–(C)(i), which directed the designation of existing provisions as par. (1), the insertion of par. (1) heading, the redesignation of former pars. (1) and (2) as subpars. (A) and (B), respectively, and former subpars. (A) and (B) of former par. (1) as cls. (i) and (ii) of subpar. (A), respectively, and the realignment of margins, was repealed by Pub. L. 111-152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (j)(1)(A). Pub. L. 111-152, § 1102(b)(1), substituted “for the area for the year (or, for 2007, 2008, 2009, and 2010, $\frac{1}{2}$ of the applicable amount determined under subsection (k)(1) for the area for the year; for 2011, $\frac{1}{2}$ of the applicable amount determined under subsection (k)(1) for the area for 2010; and, beginning with 2012, $\frac{1}{2}$ of the blended benchmark amount determined under subsection (n)(1) for the area for the year)” for “(or, beginning with 2007, $\frac{1}{2}$ of the applicable amount determined under subsection (k)(1)) for the area for the year”.

Pub. L. 111-148, § 3201(a)(1)(C)(ii), (iii), which, in cl. (i), directed substitution of “section 1395w-29(d)(2)(A) of this title, an amount equal to—” for “section 1395w-29(d)(2)(A) of this title, an amount equal to”, subcls. (I) to (VI) for “ $\frac{1}{2}$ of the annual MA capitation rate under subsection (c)(1) (or, beginning with 2007, $\frac{1}{2}$ of the applicable amount determined under subsection (k)(1)) for the area for the year, adjusted as appropriate (for years before 2007) for the purpose of risk adjust-

ment; or”, and, in cl. (ii), directed substitution of “clause (i)” for “subparagraph (A)”, was repealed by Pub. L. 111-152, § 1102(a). As enacted, subcls. (I) to (VI) read as follows:

“(I) for years before 2007, $\frac{1}{2}$ of the annual MA capitation rate under subsection (c)(1) for the area for the year, adjusted as appropriate for the purpose of risk adjustment;

“(II) for 2007 through 2011, $\frac{1}{2}$ of the applicable amount determined under subsection (k)(1) for the area for the year;

“(III) for 2012, the sum of—

“(aa) $\frac{2}{3}$ of the quotient of—

“(AA) the applicable amount determined under subsection (k)(1) for the area for the year; and

“(BB) 12; and

“(bb) $\frac{1}{3}$ of the MA competitive benchmark amount (determined under paragraph (2)) for the area for the month;

“(IV) for 2013, the sum of—

“(aa) $\frac{1}{3}$ of the quotient of—

“(AA) the applicable amount determined under subsection (k)(1) for the area for the year; and

“(BB) 12; and

“(bb) $\frac{2}{3}$ of the MA competitive benchmark amount (as so determined) for the area for the month;

“(V) for 2014, the MA competitive benchmark amount for the area for a month in 2013 (as so determined), increased by the national per capita MA growth percentage, described in subsection (c)(6) for 2014, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004; and

“(VI) for 2015 and each subsequent year, the MA competitive benchmark amount (as so determined) for the area for the month; or”.

See Effective Date of 2010 Amendment note below.

Subsec. (j)(2), (3). Pub. L. 111-148, § 3201(a)(1)(D), which directed addition of pars. (2) and (3), was repealed by Pub. L. 111-152, § 1102(a). As enacted, pars. (2) and (3) read as follows:

“(2) COMPUTATION OF MA COMPETITIVE BENCHMARK AMOUNT.—

“(A) IN GENERAL.—Subject to subparagraph (B) and paragraph (3), for months in each year (beginning with 2012) for each MA payment area the Secretary shall compute an MA competitive benchmark amount equal to the weighted average of the unadjusted MA statutory non-drug monthly bid amount (as defined in section 1395w-24(b)(2)(E) of this title) for each MA plan in the area, with the weight for each plan being equal to the average number of beneficiaries enrolled under such plan in the reference month (as defined in section 1395w-27a(f)(4) of this title, except that, in applying such definition for purposes of this paragraph, ‘to compute the MA competitive benchmark amount under section 1395w-23(j)(2) of this title’ shall be substituted for ‘to compute the percentage specified in subparagraph (A) and other relevant percentages under this part’).

“(B) WEIGHTING RULES.—

“(i) SINGLE PLAN RULE.—In the case of an MA payment area in which only a single MA plan is being offered, the weight under subparagraph (A) shall be equal to 1.

“(ii) USE OF SIMPLE AVERAGE AMONG MULTIPLE PLANS IF NO PLANS OFFERED IN PREVIOUS YEAR.—In the case of an MA payment area in which no MA plan was offered in the previous year and more than 1 MA plan is offered in the current year, the Secretary shall use a simple average of the unadjusted MA statutory non-drug monthly bid amount (as so defined) for purposes of computing the MA competitive benchmark amount under subparagraph (A).

“(3) CAP ON MA COMPETITIVE BENCHMARK AMOUNT.—In no case shall the MA competitive benchmark amount for an area for a month in a year be greater than the applicable amount that would (but for the application of this subsection) be determined under subsection (k)(1) for the area for the month in the year.”

See Effective Date of 2010 Amendment note below.

Subsec. (k)(2). Pub. L. 111-148, § 3201(a)(1)(E), (2)(A), which directed amendment of par. (2) by substituting “and subsequent years” for “through 2010” in subpar. (A) and “(j)(1)(A)(i)” for “(j)(1)(A)” in subpar. (B)(ii)(III), and by adding, in subpar. (C), cl. (v), which read “for 2011 and subsequent years, 0.00.”, was repealed by Pub. L. 111-152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (n). Pub. L. 111-152, § 1102(b)(2), added subsec. (n).

Pub. L. 111-148, § 3201(f)(1)(A), which directed addition of subsec. (n) relating to performance bonuses, was repealed by Pub. L. 111-152, § 1102(a). As enacted, text read as follows:

“(1) CARE COORDINATION AND MANAGEMENT PERFORMANCE BONUS.—

“(A) IN GENERAL.—For years beginning with 2014, subject to subparagraph (B), in the case of an MA plan that conducts 1 or more programs described in subparagraph (C) with respect to the year, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to the product of—

“(i) 0.5 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year; and

“(ii) the total number of programs described in clauses (i) through (ix) of subparagraph (C) that the Secretary determines the plan is conducting for the year under such subparagraph.

“(B) LIMITATION.—In no case may the total amount of payment with respect to a year under subparagraph (A) be greater than 2 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year, as determined prior to the application of risk adjustment under paragraph (4).

“(C) PROGRAMS DESCRIBED.—The following programs are described in this paragraph:

“(i) Care management programs that—

“(I) target individuals with 1 or more chronic conditions;

“(II) identify gaps in care; and

“(III) facilitate improved care by using additional resources like nurses, nurse practitioners, and physician assistants.

“(ii) Programs that focus on patient education and self-management of health conditions, including interventions that—

“(I) help manage chronic conditions;

“(II) reduce declines in health status; and

“(III) foster patient and provider collaboration.

“(iii) Transitional care interventions that focus on care provided around a hospital inpatient episode, including programs that target post-discharge patient care in order to reduce unnecessary health complications and readmissions.

“(iv) Patient safety programs, including provisions for hospital-based patient safety programs in contracts that the Medicare Advantage organization offering the MA plan has with hospitals.

“(v) Financial policies that promote systematic coordination of care by primary care physicians across the full spectrum of specialties and sites of care, such as medical homes, capitation arrangements, or pay-for-performance programs.

“(vi) Programs that address, identify, and ameliorate health care disparities among principal at-risk subpopulations.

“(vii) Medication therapy management programs that are more extensive than is required under section 1395w-104(c) of this title (as determined by the Secretary).

“(viii) Health information technology programs, including clinical decision support and other tools to facilitate data collection and ensure patient-centered, appropriate care.

“(ix) Such other care management and coordination programs as the Secretary determines appropriate.

“(D) CONDUCT OF PROGRAM IN URBAN AND RURAL AREAS.—An MA plan may conduct a program described in subparagraph (C) in a manner appropriate for an urban or rural area, as applicable.

“(E) REPORTING OF DATA.—Each Medicare Advantage organization shall provide to the Secretary the information needed to determine whether they are eligible for a care coordination and management performance bonus at a time and in a manner specified by the Secretary.

“(F) PERIODIC AUDITING.—The Secretary shall provide for the annual auditing of programs described in subparagraph (C) for which an MA plan receives a care coordination and management performance bonus under this paragraph. The Comptroller General shall monitor auditing activities conducted under this subparagraph.

“(2) QUALITY PERFORMANCE BONUSES.—

“(A) QUALITY BONUS.—For years beginning with 2014, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to an MA plan that achieves at least a 3 star rating (or comparable rating) on a rating system described in subparagraph (C) in an amount equal to—

“(i) in the case of a plan that achieves a 3 star rating (or comparable rating) on such system 2 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year; and

“(ii) in the case of a plan that achieves a 4 or 5 star rating (or comparable rating) on such system, 4 percent of such national monthly per capita cost for the year.

“(B) IMPROVED QUALITY BONUS.—For years beginning with 2014, in the case of an MA plan that does not receive a quality bonus under subparagraph (A) and is an improved quality MA plan with respect to the year (as identified by the Secretary), the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to 1 percent of such national monthly per capita cost for the year.

“(C) USE OF RATING SYSTEM.—For purposes of subparagraph (A), a rating system described in this paragraph is—

“(i) a rating system that uses up to 5 stars to rate clinical quality and enrollee satisfaction and performance at the Medicare Advantage contract or MA plan level; or

“(ii) such other system established by the Secretary that provides for the determination of a comparable quality performance rating to the rating system described in clause (i).

“(D) DATA USED IN DETERMINING SCORE.—

“(i) IN GENERAL.—The rating of an MA plan under the rating system described in subparagraph (C) with respect to a year shall be based on based on the most recent data available.

“(ii) PLANS THAT FAIL TO REPORT DATA.—An MA plan which does not report data that enables the Secretary to rate the plan for purposes of subparagraph (A) or identify the plan for purposes of subparagraph (B) shall be counted, for purposes of such rating or identification, as having the lowest plan performance rating and the lowest percentage improvement, respectively.

“(3) QUALITY BONUS FOR NEW AND LOW ENROLLMENT MA PLANS.—

“(A) NEW MA PLANS.—For years beginning with 2014, in the case of an MA plan that first submits a bid under section 1395w-24(a)(1)(A) of this title for 2012 or a subsequent year, only receives enrollments made during the coverage election periods described in sec-

tion 1395w-21(e) of this title, and is not able to receive a bonus under subparagraph (A) or (B) of paragraph (2) for the year, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to 2 percent of national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year. In its fourth year of operation, the MA plan shall be paid in the same manner as other MA plans with comparable enrollment.

“(B) LOW ENROLLMENT PLANS.—For years beginning with 2014, in the case of an MA plan that has low enrollment (as defined by the Secretary) and would not otherwise be able to receive a bonus under subparagraph (A) or (B) of paragraph (2) or subparagraph (A) of this paragraph for the year (referred to in this subparagraph as a ‘low enrollment plan’), the Secretary shall use a regional or local mean of the rating of all MA plans in the region or local area, as determined appropriate by the Secretary, on measures used to determine whether MA plans are eligible for a quality or an improved quality bonus, as applicable, to determine whether the low enrollment plan is eligible for a bonus under such a subparagraph.

“(4) RISK ADJUSTMENT.—The Secretary shall risk adjust a performance bonus under this subsection in the same manner as the Secretary risk adjusts beneficiary rebates described in section 1395w-24(b)(1)(C) of this title.

“(5) NOTIFICATION.—The Secretary, in the annual announcement required under subsection (b)(1)(B) for 2014 and each succeeding year, shall notify the Medicare Advantage organization of any performance bonus (including a care coordination and management performance bonus under paragraph (1), a quality performance bonus under paragraph (2), and a quality bonus for new and low enrollment plans under paragraph (3)) that the organization will receive under this subsection with respect to the year. The Secretary shall provide for the publication of the information described in the previous sentence on the Internet website of the Centers for Medicare & Medicaid Services.”

See Effective Date of 2010 Amendment note below.

Subsec. (n)(2)(B). Pub. L. 111-152, §1102(c)(2), which directed insertion of “, subject to subsection (o)” after “as follows” could not be executed because “as follows” did not appear in text.

Subsec. (n)(6). Pub. L. 111-148, §3202(b)(2), which directed that subsec. (n), as added by Pub. L. 111-148, §3201(f), be amended by adding a par. (6), was not executed to reflect the probable intent of Congress and the subsequent repeal of §3201(f) by Pub. L. 111-152, §1102(a). See Amendment note above.

Subsec. (o). Pub. L. 111-152, §1102(c)(3), added subsec. (o).

Pub. L. 111-148, §3201(g), which directed addition of subsec. (o) relating to grandfathering supplemental benefits for current enrollees after implementation of competitive bidding, was repealed by Pub. L. 111-152, §1102(a). As enacted, text read as follows:

“(1) IDENTIFICATION OF AREAS.—The Secretary shall identify MA local areas in which, with respect to 2009, average bids submitted by an MA organization under section 1395w-24(a) of this title for MA local plans in the area are not greater than 75 percent of the adjusted average per capita cost for the year involved, determined under section 1395mm(a)(4) of this title, for the area for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1395w-4(o), 1395ww(n), and 1395ww(h) of this title.

“(2) ELECTION TO PROVIDE REBATES TO GRANDFATHERED ENROLLEES.—

“(A) IN GENERAL.—For years beginning with 2012, each Medicare Advantage organization offering an MA local plan in an area identified by the Secretary under paragraph (1) may elect to provide rebates to grandfathered enrollees under section

1395w-24(b)(1)(C) of this title. In the case where an MA organization makes such an election, the monthly per capita dollar amount of such rebates shall not exceed the applicable amount for the year (as defined in subparagraph (B)).

“(B) APPLICABLE AMOUNT.—For purposes of this subsection, the term ‘applicable amount’ means—

“(i) for 2012, the monthly per capita dollar amount of such rebates provided to enrollees under the MA local plan with respect to 2011; and

“(ii) for a subsequent year, 95 percent of the amount determined under this subparagraph for the preceding year.

“(3) SPECIAL RULES FOR PLANS IN IDENTIFIED AREAS.—Notwithstanding any other provision of this part, the following shall apply with respect to each Medicare Advantage organization offering an MA local plan in an area identified by the Secretary under paragraph (1) that makes an election described in paragraph (2):

“(A) PAYMENTS.—The amount of the monthly payment under this section to the Medicare Advantage organization, with respect to coverage of a grandfathered enrollee under this part in the area for a month, shall be equal to—

“(i) for 2012 and 2013, the sum of—

“(I) the bid amount under section 1395w-24(a) of this title for the MA local plan; and

“(II) the applicable amount (as defined in paragraph (2)(B)) for the MA local plan for the year.

“(ii) for 2014 and subsequent years, the sum of—

“(I) the MA competitive benchmark amount under subsection (j)(1)(A)(i) for the area for the month, adjusted, only to the extent the Secretary determines necessary, to account for induced utilization as a result of rebates provided to grandfathered enrollees (except that such adjustment shall not exceed 0.5 percent of such MA competitive benchmark amount); and

“(II) the applicable amount (as so defined) for the MA local plan for the year.

“(B) REQUIREMENT TO SUBMIT BIDS UNDER COMPETITIVE BIDDING.—The Medicare Advantage organization shall submit a single bid amount under section 1395w-24(a) of this title for the MA local plan. The Medicare Advantage organization shall remove from such bid amount any effects of induced demand for care that may result from the higher rebates available to grandfathered enrollees under this subsection.

“(C) NONAPPLICATION OF BONUS PAYMENTS AND ANY OTHER REBATES.—The Medicare Advantage organization offering the MA local plan shall not be eligible for any bonus payment under subsection (n) or any rebate under this part (other than as provided under this subsection) with respect to grandfathered enrollees.

“(D) NONAPPLICATION OF UNIFORM BID AND PREMIUM AMOUNTS TO GRANDFATHERED ENROLLEES.—Section 1395w-24(c) of this title shall not apply with respect to the MA local plan.

“(E) NONAPPLICATION OF LIMITATION ON APPLICATION OF PLAN REBATES TOWARD PAYMENT OF PART B PREMIUM.—Notwithstanding clause (iii) of section 1395w-24(b)(1)(C) of this title, in the case of a grandfathered enrollee, a rebate under such section may be used for the purpose described in clause (ii)(III) of such section.

“(F) RISK ADJUSTMENT.—The Secretary shall risk adjust rebates to grandfathered enrollees under this subsection in the same manner as the Secretary risk adjusts beneficiary rebates described in section 1395w-24(b)(1)(C) of this title.

“(4) DEFINITION OF GRANDFATHERED ENROLLEE.—In this subsection, the term ‘grandfathered enrollee’ means an individual who is enrolled (effective as of March 23, 2010) in an MA local plan in an area that is identified by the Secretary under paragraph (1).”

See Effective Date of 2010 Amendment note below.

Subsec. (p). Pub. L. 111-148, § 3201(h), which directed addition of subsec. (p) relating to transitional extra benefits, was repealed by Pub. L. 111-152, § 1102(a). As enacted, text read as follows:

“(1) IN GENERAL.—For years beginning with 2012, the Secretary shall provide transitional rebates under section 1395w-24(b)(1)(C) of this title for the provision of extra benefits (as specified by the Secretary) to enrollees described in paragraph (2).

“(2) ENROLLEES DESCRIBED.—An enrollee described in this paragraph is an individual who—

“(A) enrolls in an MA local plan in an applicable area; and

“(B) experiences a significant reduction in extra benefits described in clause (ii) of section 1395w-24(b)(1)(C) of this title as a result of competitive bidding under this part (as determined by the Secretary).

“(3) APPLICABLE AREAS.—In this subsection, the term ‘applicable area’ means the following:

“(A) The 2 largest metropolitan statistical areas, if the Secretary determines that the total amount of such extra benefits for each enrollee for the month in those areas is greater than \$100.

“(B) A county where—

“(i) the MA area-specific non-drug monthly benchmark amount for a month in 2011 is equal to the legacy urban floor amount (as described in subsection (c)(1)(B)(iii)), as determined by the Secretary for the area for 2011;

“(ii) the percentage of Medicare Advantage eligible beneficiaries in the county who are enrolled in an MA plan for 2009 is greater than 30 percent (as determined by the Secretary); and

“(iii) average bids submitted by an MA organization under section 1395w-24(a) of this title for MA local plans in the county for 2011 are not greater than the adjusted average per capita cost for the year involved, determined under section 1395mm(a)(4) of this title, for the county for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1395w-4(o), 1395ww(n), and 1395ww(h) of this title.

“(C) If the Secretary determines appropriate, a county contiguous to an area or county described in subparagraph (A) or (B), respectively.

“(4) REVIEW OF PLAN BIDS.—In the case of a bid submitted by an MA organization under section 1395w-24(a) of this title for an MA local plan in an applicable area, the Secretary shall review such bid in order to ensure that extra benefits (as specified by the Secretary) are provided to enrollees described in paragraph (2).

“(5) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1395i of this title and the Federal Supplementary Medical Insurance Trust Fund established under section 1395t of this title, in such proportion as the Secretary determines appropriate, of an amount not to exceed \$5,000,000,000 for the period of fiscal years 2012 through 2019 for the purpose of providing transitional rebates under section 1395w-24(b)(1)(C) of this title for the provision of extra benefits under this subsection.”

See Effective Date of 2010 Amendment note below.

Subsec. (p)(3)(A). Pub. L. 111-148, § 10318, which directed that subsec. (p)(3)(A), as added by Pub. L. 111-148, § 3201(h), be amended by inserting “in 2009” before the period at the end, was not executed to reflect the probable intent of Congress and the subsequent repeal of § 3201(h) by Pub. L. 111-152, § 1102(a). See Amendment note above.

2009—Subsec. (a)(1)(A). Pub. L. 111-5, § 4101(e)(1), substituted “(i), and (l)” for “and (i)”.

Subsec. (c)(1)(D)(i). Pub. L. 111-5, § 4102(d)(3)(A)(i), substituted “, 1395w-4(o), and 1395ww(n)” for “1395w-4(o)”.

Pub. L. 111-5, § 4101(e)(2)(A), substituted “sections 1395w-4(o) and 1395ww(h) of this title” for “section 1395ww(h) of this title”.

Subsec. (c)(6)(A). Pub. L. 111-5, § 4102(d)(3)(A)(ii), inserted “and subsections (b)(3)(B)(ix) and (n) of section 1395ww of this title” after “1395w-4 of this title”.

Pub. L. 111-5, § 4101(e)(2)(B), inserted “excluding expenditures attributable to subsections (a)(7) and (o) of

section 1395w-4 of this title,” after “under part B of this subchapter.”

Subsec. (f). Pub. L. 111-5, § 4102(d)(3)(B), inserted “and subsection (m)” after “under subsection (l)”.

Pub. L. 111-5, § 4101(e)(3), inserted “and for payments under subsection (l)” after “with the organization”.

Subsec. (l). Pub. L. 111-5, § 4101(c), added subsec. (l).

Subsec. (m). Pub. L. 111-5, § 4102(c), added subsec. (m). 2008—Subsec. (k)(1). Pub. L. 110-275, § 161(a)(1), (b), substituted “paragraphs (2) and (4)” for “paragraph (2)” in introductory provisions and cl. (i) of subpar. (B).

Subsec. (k)(4). Pub. L. 110-275, § 161(a)(2), added par. (4).

2006—Subsec. (a)(1)(C). Pub. L. 109-171, § 5301(b), designated existing provisions as cl. (i), inserted heading, and added cl. (ii).

Subsec. (j)(1)(A). Pub. L. 109-171, § 5301(a)(1)(A), inserted “(or, beginning with 2007, ½ of the applicable amount determined under subsection (k)(1))” after “subsection (c)(1)” and “(for years before 2007)” after “adjusted as appropriate”.

Subsec. (j)(1)(B). Pub. L. 109-171, § 5301(a)(1)(B), inserted “(for years before 2007)” after “adjusted as appropriate”.

Subsec. (k). Pub. L. 109-171, § 5301(a)(2), added subsec. (k).

2003—Subsec. (a)(1)(A). Pub. L. 108-173, § 222(e)(1)(B), substituted “amount determined as follows:” and cls. (i) and (ii) for “amount” and provisions describing amount equal to ½ of the annual Medicare+Choice capitation rate, reduced by the amount of any reduction elected under section 1395w-24(f)(1)(E) of this title and adjusted for certain factors.

Subsec. (a)(1)(B) to (G). Pub. L. 108-173, § 222(e)(1)(B), added subpars. (B) to (G). Former subpar. (B) redesignated (H).

Subsec. (a)(1)(H). Pub. L. 108-173, § 222(i), substituted as second sentence provisions relating to actuarial equivalence of rates of payment to rates that would have been paid with respect to other enrollees in the MA payment area under this section as in effect before Dec. 8, 2003, for provisions relating to actuarial equivalence of rates of payment to rates paid to other enrollees in the Medicare+Choice payment area and inserted sentence at end authorizing application of the competitive bidding methodology provided for in this section, with appropriate adjustments to account for the risk adjustment methodology applied to end stage renal disease payments.

Pub. L. 108-173, § 222(e)(1)(A), redesignated subpar. (B) as (H).

Subsec. (a)(3)(C)(ii). Pub. L. 108-173, § 736(d)(1)(A), substituted “clause (iv)” for “clause (iii)” in introductory provisions.

Subsec. (a)(3)(C)(iii), (iv). Pub. L. 108-173, § 736(d)(1)(B), redesignated cl. (iii), relating to full implementation of risk adjustment for congestive heart failure enrollees for 2001, as (iv).

Subsec. (a)(4). Pub. L. 108-173, § 237(b)(1), added par. (4).

Subsec. (b)(1). Pub. L. 108-173, § 222(f)(1), amended heading and text of par. (1) generally, substituting provisions relating to announcements of payment rates for 2005 and for 2006 and subsequent years for provisions relating to announcement for years before 2004, for 2004 and 2005, and for years after 2005.

Subsec. (b)(1)(B)(iii). Pub. L. 108-173, § 241(b)(1)(B), added cl. (iii).

Subsec. (b)(3). Pub. L. 108-173, § 222(f)(2), substituted “in such announcement” for “in the announcement in sufficient detail so that Medicare+Choice organizations can compute monthly adjusted Medicare+Choice capitation rates for individuals in each Medicare+Choice payment area which is in whole or in part within the service area of such an organization”.

Subsec. (b)(4). Pub. L. 108-173, § 900(e)(1)(G)(i), substituted “Centers for Medicare & Medicaid Services” for “Health Care Financing Administration” in introductory provisions.

Subsec. (c)(1). Pub. L. 108-173, § 221(d)(4), inserted “that is an MA local area” after “for a

Medicare+Choice payment area” in introductory provisions.

Pub. L. 108-173, § 211(a)(2), substituted “(C), or (D)” for “or (C)” in introductory provisions.

Subsec. (c)(1)(A). Pub. L. 108-173, § 211(b)(1), (c)(1)(A), substituted “For a year before 2005, the sum” for “The sum” in introductory provisions and inserted “(for a year other than 2004)” after “multiplied” in concluding provisions.

Subsec. (c)(1)(B)(iv). Pub. L. 108-173, § 211(c)(1)(B), substituted “, 2003, and 2004” for “and each succeeding year”.

Subsec. (c)(1)(C)(iv). Pub. L. 108-173, § 211(c)(1)(C), substituted “and 2003” for “and each succeeding year”.

Subsec. (c)(1)(C)(v). Pub. L. 108-173, § 211(c)(1)(D), added cl. (v).

Subsec. (c)(1)(D). Pub. L. 108-173, § 211(a)(1), added subpar. (D).

Subsec. (c)(3)(A). Pub. L. 108-173, § 211(d)(1), substituted “subparagraphs (B) and (E)” for “subparagraph (B)” in introductory provisions.

Subsec. (c)(3)(E). Pub. L. 108-173, § 211(d)(2), added subpar. (E).

Subsec. (c)(5). Pub. L. 108-173, § 736(d)(1)(C), substituted “(a)(3)(C)(iv)” for “(a)(3)(C)(iii)”.

Pub. L. 108-173, § 237(b)(2)(B), substituted “subsections (a)(3)(C)(iii), (a)(4), and (i)” for “subsections (a)(3)(C)(iii) and (i)”.

Pub. L. 108-173, § 211(b)(2), inserted “(other than 2004)” after “for each year”.

Subsec. (c)(6)(C). Pub. L. 108-173, § 211(c)(2), inserted “, except that for purposes of paragraph (1)(C)(v)(II), no such adjustment shall be made for a year before 2004” before period at end.

Subsec. (c)(7). Pub. L. 108-173, § 900(e)(1)(G)(ii), substituted “Centers for Medicare & Medicaid Services” for “Health Care Financing Administration”.

Subsec. (d). Pub. L. 108-173, § 221(d)(1)(A), substituted “MA payment area; MA local area; MA region defined” for “‘Medicare+Choice payment area’ defined” in heading.

Subsec. (d)(1). Pub. L. 108-173, § 221(d)(1)(C), amended heading and text of par. (1) generally. Prior to amendment, text read as follows: “In this part, except as provided in paragraph (3), the term ‘Medicare+Choice payment area’ means a county, or equivalent area specified by the Secretary.”

Subsec. (d)(2), (3). Pub. L. 108-173, § 221(d)(1)(B), (D), added par. (2) and redesignated former par. (2) as (3). Former par. (3) redesignated (4).

Subsec. (d)(4). Pub. L. 108-173, § 221(d)(1)(B), redesignated par. (3) as (4).

Subsec. (d)(4)(A). Pub. L. 108-173, § 221(d)(1)(E)(i), inserted “for MA local plans” after “paragraph (1)” in introductory provisions.

Subsec. (d)(4)(A)(iii). Pub. L. 108-173, § 221(d)(1)(E)(ii), substituted “paragraph (1)(A)” for “paragraph (1)”.

Subsec. (d)(4)(B). Pub. L. 108-173, § 221(d)(1)(E)(iii), inserted “with respect to MA local plans” after “established under this section” and “for such plans” after “payments under this section” and “made under this section”.

Subsec. (f). Pub. L. 108-173, § 101(e)(3)(D), in heading, substituted “Trust Funds” for “Trust Fund” and, after first sentence, inserted “Payments to MA organizations for statutory drug benefits provided under this subchapter are made from the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.”

Subsec. (g). Pub. L. 108-173, § 211(e)(1)(A), inserted “, a rehabilitation hospital described in section 1395ww(d)(1)(B)(ii) of this title or a distinct part rehabilitation unit described in the matter following clause (v) of section 1395ww(d)(1)(B) of this title, or a long-term care hospital (described in section 1395ww(d)(1)(B)(iv) of this title)” after “1395ww(d)(1)(B) of this title” in introductory provisions.

Subsec. (g)(2)(B). Pub. L. 108-173, § 211(e)(1)(B), inserted “or other payment provision under this subchapter for inpatient services for the type of facility,

hospital, or unit involved, described in the matter preceding paragraph (1), as the case may be,” after “1395ww(d) of this title”.

Subsec. (j). Pub. L. 108-173, § 222(d), added subsec. (j).

Subsec. (j)(1)(A). Pub. L. 108-173, § 241(b)(1)(A), inserted “subject to section 1395w-29(d)(2)(A) of this title,” after “within an MA local area.”.

2002—Subsec. (b)(1). Pub. L. 107-188 in introductory provisions substituted “for years before 2004 and after 2005 not later than March 1 before the calendar year concerned and for 2004 and 2005 not later than the second Monday in May before the respective calendar year” for “not later than March 1 before the calendar year concerned”.

2000—Subsec. (a)(1)(A). Pub. L. 106-554, § 1(a)(6) [title VI, § 606(a)(2)(A)], inserted “reduced by the amount of any reduction elected under section 1395w-24(f)(1)(E) of this title and” after “for that area.”.

Subsec. (a)(1)(B). Pub. L. 106-554, § 1(a)(6) [title VI, § 605(a)], inserted at end “In establishing such rates, the Secretary shall provide for appropriate adjustments to increase each rate to reflect the demonstration rate (including the risk adjustment methodology associated with such rate) of the social health maintenance organization end-stage renal disease capitation demonstrations (established by section 2355 of the Deficit Reduction Act of 1984, as amended by section 13567(b) of the Omnibus Budget Reconciliation Act of 1993), and shall compute such rates by taking into account such factors as renal treatment modality, age, and the underlying cause of the end-stage renal disease.”

Subsec. (a)(3)(C)(ii). Pub. L. 106-554, § 1(a)(6) [title VI, § 607(a)(1)], substituted “Except as provided in clause (iii), such risk adjustment” for “Such risk adjustment”.

Subsec. (a)(3)(C)(ii)(I). Pub. L. 106-554, § 1(a)(6) [title VI, § 603(1)(A)], substituted “and each succeeding year through 2003” for “and 2001” and struck out “and” at end.

Subsec. (a)(3)(C)(ii)(II) to (V). Pub. L. 106-554, § 1(a)(6) [title VI, § 603(1)(B)], added subcls. (II) to (V) and struck out former subcl. (II) which read as follows: “not more than 20 percent of such capitation rate in 2002.”

Subsec. (a)(3)(C)(iii). Pub. L. 106-554, § 1(a)(6) [title VI, § 607(a)(2)], added cl. (iii) relating to full implementation of risk adjustment for congestive heart failure enrollees for 2001.

Pub. L. 106-554, § 1(a)(6) [title VI, § 603(2)], added cl. (iii) relating to data for risk adjustment methodology.

Subsec. (c)(1)(B)(ii), (iii). Pub. L. 106-554, § 1(a)(6) [title VI, § 601(a)(2)], added cls. (ii) and (iii). Former cl. (ii) redesignated (iv).

Subsec. (c)(1)(B)(iv). Pub. L. 106-554, § 1(a)(6) [title VI, § 601(a)(1), (3)], redesignated cl. (ii) as (iv) and substituted “2002 and each succeeding year” for “a succeeding year” and “clause (iii)” for “clause (i)”.

Subsec. (c)(1)(C)(ii), (iii). Pub. L. 106-554, § 1(a)(6) [title VI, § 602(a)(2)], added cls. (ii) and (iii). Former cl. (ii) redesignated (iv).

Subsec. (c)(1)(C)(iv). Pub. L. 106-554, § 1(a)(6) [title VI, § 602(a)(1), (3)], redesignated cl. (ii) as (iv) and substituted “2002 and each succeeding year” for “a subsequent year”.

Subsec. (c)(5). Pub. L. 106-554, § 1(a)(6) [title VI, § 607(b)], substituted “subsections (a)(3)(C)(iii) and (i)” for “subsection (i)”.

Subsec. (c)(7). Pub. L. 106-554, § 1(a)(6) [title VI, § 611(a)], amended heading and text of par. (7) generally. Prior to amendment, text read as follows: “If the Secretary makes a determination with respect to coverage under this subchapter that the Secretary projects will result in a significant increase in the costs to Medicare+Choice of providing benefits under contracts under this part (for periods after any period described in section 1395w-22(a)(5) of this title), the Secretary shall adjust appropriately the payments to such organizations under this part.”

Subsec. (i)(1). Pub. L. 106-554, § 1(a)(6) [title VI, § 608(a)], in introductory provisions, inserted “, or filed notice with the Secretary as of October 3, 2000, that

they will not be offering such a plan as of January 1, 2001” after “January 1, 2000”.

1999—Subsec. (a)(1)(A). Pub. L. 106-113, § 1000(a)(6) [title V, § 512(1)], substituted “subsections (e), (g), and (i) of this section” for “subsections (e) and (f) of this section”.

Subsec. (a)(3)(C). Pub. L. 106-113, § 1000(a)(6) [title V, § 511(a)], designated existing provisions as cl. (i), inserted heading, and added cl. (ii).

Subsec. (b)(4). Pub. L. 106-113, § 1000(a)(6) [title V, § 514(a)], added par. (4).

Subsec. (c)(5). Pub. L. 106-113, § 1000(a)(6) [title V, § 512(2)], inserted “(other than those attributable to subsection (i) of this section)” after “payments under this part”.

Subsec. (c)(6)(B)(v). Pub. L. 106-113, § 1000(a)(6) [title V, § 517], substituted “0.3 percentage points” for “0.5 percentage points”.

Subsec. (i). Pub. L. 106-113, § 1000(a)(6) [title V, § 512(3)], added subsec. (i).

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108-173, set out as a note under section 1395w-21 of this title.

EFFECTIVE DATE OF 2015 AMENDMENT

Amendment by Pub. L. 114-113 applicable as if included in the enactment of Pub. L. 111-5, with certain exceptions, see section 602(d) of Pub. L. 114-113, set out as a note under section 1395ww of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Repeal of sections 3201 and 3203 of Pub. L. 111-148 and the amendments made by such sections, effective as if included in the enactment of Pub. L. 111-148, see section 1102(a) of Pub. L. 111-152, set out as a note under section 1395w-21 of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108-173, title II, § 211(e)(2), Dec. 8, 2003, 117 Stat. 2178, provided that: “The amendments made by paragraph (1) [amending this section] shall apply to contract years beginning on or after January 1, 2004.”

Amendment by sections 221(d)(1), (4) and 222(d)-(f), (i) of Pub. L. 108-173 applicable with respect to plan years beginning on or after Jan. 1, 2006, see section 223(a) of Pub. L. 108-173, set out as a note under section 1395w-21 of this title.

Amendment by section 237(b)(1), (2)(B) of Pub. L. 108-173 applicable to services provided on or after Jan. 1, 2006, and contract years beginning on or after such date, see section 237(e) of Pub. L. 108-173, set out as a note under section 1320a-7b of this title.

EFFECTIVE DATE OF 2002 AMENDMENT

Pub. L. 107-188, title V, § 532(d)(2), June 12, 2002, 116 Stat. 697, provided that: “The amendment made by paragraph (1) [amending this section] shall first apply to announcements for years after 2003.”

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106-554, § 1(a)(6) [title VI, § 605(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-556, provided that: “The amendment made by subsection (a) [amending this section] shall apply to payments for months beginning with January 2002.”

Amendment by section 1(a)(6) [title VI, § 606(a)(2)(A)] of Pub. L. 106-554 applicable to years beginning with 2003, see section 1(a)(6) [title VI, § 606(b)] of Pub. L. 106-554, set out as a note under section 1395r of this title.

Pub. L. 106-554, § 1(a)(6) [title VI, § 608(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-559, provided that: “The amendment made by subsection (a) [amending this sec-

tion] shall apply as if included in the enactment of BBRA [Pub. L. 106-113, §1000(a)(6)].”

Amendment by section 1(a)(6) [title VI, §611(a)] of Pub. L. 106-554 effective Dec. 21, 2000, and applicable to national coverage determinations and legislative changes in benefits occurring on or after such date, see section 1(a)(6) [title VI, §611(c)] of Pub. L. 106-554, set out as a note under section 1395w-22 of this title.

MEDPAC STUDY OF AAPCC

Pub. L. 108-173, title II, §211(f), Dec. 8, 2003, 117 Stat. 2178, directed the Medicare Payment Advisory Commission to conduct a study that would assess the method used for determining the adjusted average per capita cost (AAPCC) under section 1395mm(a)(4) of this title, as applied under subsection (c)(1)(A) of this section, and to submit to Congress a report on such study not later than 18 months after Dec. 8, 2003.

IMPLEMENTATION OF 2003 AMENDMENT

Pub. L. 108-173, title II, §211(i), Dec. 8, 2003, 117 Stat. 2179, provided that:

“(1) ANNOUNCEMENT OF REVISED MEDICARE ADVANTAGE PAYMENT RATES.—Within 6 weeks after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall determine, and shall announce (in a manner intended to provide notice to interested parties) MA capitation rates under section 1853 of the Social Security Act (42 U.S.C. 1395w-23) for 2004, revised in accordance with the provisions of this section [amending this section and section 1395w-22 of this title and enacting provisions set out as notes under this section and section 1395w-21 of this title].

“(2) TRANSITION TO REVISED PAYMENT RATES.—The provisions of section 604 of BIPA [the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, H.R. 5661, as enacted by section 1(a)(6) of Public Law 106-554, set out as a note under this section] (114 Stat. 2763A-555) (other than subsection (a)) shall apply to the provisions of subsections (a) through (d) of this section [amending this section] for 2004 in the same manner as the provisions of such section 604 applied to the provisions of BIPA for 2001.

“(3) SPECIAL RULE FOR PAYMENT RATES IN 2004.—

“(A) JANUARY AND FEBRUARY.—Notwithstanding the amendments made by subsections (a) through (d) [amending this section], for purposes of making payments under section 1853 of the Social Security Act (42 U.S.C. 1395w-23) for January and February 2004, the annual capitation rate for a payment area shall be calculated and the excess amount under section 1854(f)(1)(B) of such Act (42 U.S.C. 1395w-24(f)(1)(B)) shall be determined as if such amendments had not been enacted.

“(B) MARCH THROUGH DECEMBER.—Notwithstanding the amendments made by subsections (a) through (d) [amending this section], for purposes of making payments under section 1853 of the Social Security Act (42 U.S.C. 1395w-23) for March through December 2004, the annual capitation rate for a payment area shall be calculated and the excess amount under section 1854(f)(1)(B) of such Act (42 U.S.C. 1395w-24(f)(1)(B)) shall be determined, in such manner as the Secretary estimates will ensure that the total of such payments with respect to 2004 is the same as the amounts that would have been if subparagraph (A) had not been enacted.

“(C) CONSTRUCTION.—Subparagraphs (A) and (B) shall not be taken into account in computing such capitation rate for 2005 and subsequent years.

“(4) PLANS REQUIRED TO PROVIDE NOTICE OF CHANGES IN PLAN BENEFITS.—In the case of an organization offering a plan under part C of title XVIII of the Social Security Act [this part] that revises its submission of the information described in section 1854(a)(1) of such Act (42 U.S.C. 1395w-23(a)(1)) [1395w-24(a)(1)] for a plan pursuant to the application of paragraph (2), if such revision results in changes in beneficiary premiums, beneficiary cost-sharing, or benefits under the plan, then by not

later than 3 weeks after the date the Secretary approves such submission, the organization offering the plan shall provide each beneficiary enrolled in the plan with written notice of such changes.

“(5) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869 or section 1878 of the Social Security Act (42 U.S.C. 1395ff and 1395oo), or otherwise of any determination made by the Secretary under this subsection or the application of the payment rates determined pursuant to this subsection.”

SPECIAL RULE FOR JANUARY AND FEBRUARY OF 2001

Pub. L. 106-554, §1(a)(6) [title VI, §601(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-554, provided that:

“(1) IN GENERAL.—Notwithstanding the amendments made by subsection (a) [amending this section], for purposes of making payments under section 1853 of the Social Security Act (42 U.S.C. 1395w-23) for January and February 2001, the annual Medicare+Choice capitation rate for a Medicare+Choice payment area shall be calculated, and the excess amount under section 1854(f)(1)(B) of such Act (42 U.S.C. 1395w-24(f)(1)(B)) shall be determined, as if such amendments had not been enacted.

“(2) CONSTRUCTION.—Paragraph (1) shall not be taken into account in computing such capitation rate for 2002 and subsequent years.”

Pub. L. 106-554, §1(a)(6) [title VI, §602(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-555, provided that: “The provisions of section 601(b) [set out above] shall apply with respect to the amendments made by subsection (a) [amending this section] in the same manner as they apply to the amendments made by section 601(a) [amending this section].”

TRANSITION TO REVISED MEDICARE+CHOICE PAYMENT RATES

Pub. L. 106-554, §1(a)(6) [title VI, §604], Dec. 21, 2000, 114 Stat. 2763, 2763A-555, provided that:

“(a) ANNOUNCEMENT OF REVISED MEDICARE+CHOICE PAYMENT RATES.—Within 2 weeks after the date of the enactment of this Act [Dec. 21, 2000], the Secretary of Health and Human Services shall determine, and shall announce (in a manner intended to provide notice to interested parties) Medicare+Choice capitation rates under section 1853 of the Social Security Act (42 U.S.C. 1395w-23) for 2001, revised in accordance with the provisions of this Act.

“(b) REENTRY INTO PROGRAM PERMITTED FOR MEDICARE+CHOICE PROGRAMS.—A Medicare+Choice organization that provided notice to the Secretary of Health and Human Services before the date of the enactment of this Act [Dec. 21, 2000] that it was terminating its contract under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w-21 et seq.] or was reducing the service area of a Medicare+Choice plan offered under such part shall be permitted to continue participation under such part, or to maintain the service area of such plan, for 2001 if it submits the Secretary with the information described in section 1854(a)(1) of the Social Security Act (42 U.S.C. 1395w-24(a)(1)) within 2 weeks after the date revised rates are announced by the Secretary under subsection (a).

“(c) REVISED SUBMISSION OF PROPOSED PREMIUMS AND RELATED INFORMATION.—If—

“(1) a Medicare+Choice organization provided notice to the Secretary of Health and Human Services as of July 3, 2000, that it was renewing its contract under part C of title XVIII of the Social Security Act [this part] for all or part of the service area or areas served under its current contract, and

“(2) any part of the service area or areas addressed in such notice includes a payment area for which the Medicare+Choice capitation rate under section 1853(c) of such Act (42 U.S.C. 1395w-23(c)) for 2001, as determined under subsection (a), is higher than the rate previously determined for such year,

such organization shall revise its submission of the information described in section 1854(a)(1) of the Social Security Act (42 U.S.C. 1395w-24(a)(1)), and shall submit such revised information to the Secretary, within 2 weeks after the date revised rates are announced by the Secretary under subsection (a). In making such submission, the organization may only reduce beneficiary premiums, reduce beneficiary cost-sharing, enhance benefits, utilize the stabilization fund described in section 1854(f)(2) of such Act (42 U.S.C. 1395w-24(f)(2)), or stabilize or enhance beneficiary access to providers (so long as such stabilization or enhancement does not result in increased beneficiary premiums, increased beneficiary cost-sharing, or reduced benefits).

“(d) WAIVER OF LIMITS ON STABILIZATION FUND.—Any regulatory provision that limits the proportion of the excess amount that can be withheld in such stabilization fund for a contract period shall not apply with respect to submissions described in subsections (b) and (c).

“(e) DISREGARD OF NEW RATE ANNOUNCEMENT IN APPLYING PASS-THROUGH FOR NEW NATIONAL COVERAGE DETERMINATIONS.—For purposes of applying section 1852(a)(5) of the Social Security Act (42 U.S.C. 1395w-22(a)(5)), the announcement of revised rates under subsection (a) shall not be treated as an announcement under section 1853(b) of such Act (42 U.S.C. 1395w-23(b)).”

PUBLICATION

Pub. L. 106-554, §1(a)(6) [title VI, §605(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A-556, provided that: “Not later than 6 months after the date of the enactment of this Act [Dec. 21, 2000], the Secretary of Health and Human Services shall publish for public comment a description of the appropriate adjustments described in the last sentence of section 1853(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w-23(a)(1)(B)), as added by subsection (a). The Secretary shall publish such adjustments in final form by not later than July 1, 2001, so that the amendment made by subsection (a) is implemented on a timely basis consistent with subsection (b) [set out as a note above].”

REPORT ON INCLUSION OF CERTAIN COSTS OF THE DEPARTMENT OF VETERANS AFFAIRS AND MILITARY FACILITY SERVICES IN CALCULATING MEDICARE+CHOICE PAYMENT RATES

Pub. L. 106-554, §1(a)(6) [title VI, §609], Dec. 21, 2000, 114 Stat. 2763, 2763A-559, provided that: “The Secretary of Health and Human Services shall report to Congress by not later than January 1, 2003, on a method to phase-in the costs of military facility services furnished by the Department of Veterans Affairs, and the costs of military facility services furnished by the Department of Defense, to medicare-eligible beneficiaries in the calculation of an area’s Medicare+Choice capitation payment. Such report shall include on a county-by-county basis—

- “(1) the actual or estimated cost of such services to medicare-eligible beneficiaries;
- “(2) the change in Medicare+Choice capitation payment rates if such costs are included in the calculation of payment rates;
- “(3) one or more proposals for the implementation of payment adjustments to Medicare+Choice plans in counties where the payment rate has been affected due to the failure to calculate the cost of such services to medicare-eligible beneficiaries; and
- “(4) a system to ensure that when a Medicare+Choice enrollee receives covered services through a facility of the Department of Veterans Affairs or the Department of Defense there is an appropriate payment recovery to the medicare program under title XVIII of the Social Security Act [this subchapter].”

MEDPAC STUDY AND REPORT

Pub. L. 106-113, div. B, §1000(a)(6) [title V, §511(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A-380, provided that:

“(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study that evaluates the methodology used by the Secretary of Health and Human Services in developing the risk factors used in adjusting the Medicare+Choice capitation rate paid to Medicare+Choice organizations under section 1853 of the Social Security Act (42 U.S.C. 1395w-23) and includes the issues described in paragraph (2).

“(2) ISSUES TO BE STUDIED.—The issues described in this paragraph are the following:

“(A) The ability of the average risk adjustment factor applied to a Medicare+Choice plan to explain variations in plans’ average per capita medicare costs, as reported by Medicare+Choice plans in the plans’ adjusted community rate filings.

“(B) The year-to-year stability of the risk factors applied to each Medicare+Choice plan and the potential for substantial changes in payment for small Medicare+Choice plans.

“(C) For medicare beneficiaries newly enrolled in Medicare+Choice plans in a given year, the correspondence between the average risk factor calculated from medicare fee-for-service data for those individuals from the period prior to their enrollment in a Medicare+Choice plan and the average risk factor calculated for such individuals during their initial year of enrollment in a Medicare+Choice plan.

“(D) For medicare beneficiaries disenrolling from or switching among Medicare+Choice plans in a given year, the correspondence between the average risk factor calculated from data pertaining to the period prior to their disenrollment from a Medicare+Choice plan and the average risk factor calculated from data pertaining to the period after disenrollment.

“(E) An evaluation of the exclusion of ‘discretionary’ hospitalizations from consideration in the risk adjustment methodology.

“(F) Suggestions for changes or improvements in the risk adjustment methodology.

“(3) REPORT.—Not later than December 1, 2000, the Commission shall submit a report to Congress on the study conducted under paragraph (1), together with any recommendations for legislation that the Commission determines to be appropriate as a result of such study.”

STUDY AND REPORT REGARDING REPORTING OF ENCOUNTER DATA

Pub. L. 106-113, div. B, §1000(a)(6) [title V, §511(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A-381, provided that:

“(1) STUDY.—The Secretary of Health and Human Services shall conduct a study on how to reduce the costs and burdens on Medicare+Choice organizations of their complying with reporting requirements for encounter data imposed by the Secretary in establishing and implementing a risk adjustment methodology used in making payments to such organizations under section 1853 of the Social Security Act (42 U.S.C. 1395w-23). The Secretary shall consult with representatives of Medicare+Choice organizations in conducting the study. The study shall address the following issues:

“(A) Limiting the number and types of sites of services (that are in addition to inpatient sites) for which encounter data must be reported.

“(B) Establishing alternative risk adjustment methods that would require submission of less data.

“(C) The potential for Medicare+Choice organizations to misreport, overreport, or underreport prevalence of diagnoses in outpatient sites of care, the potential for increases in payments to Medicare+Choice organizations from changes in Medicare+Choice plan coding practices (commonly known as ‘coding creep’) and proposed methods for detecting and adjusting for such variations in diagnosis coding as part of the risk adjustment methodology using encounter data from multiple sites of care.

“(D) The impact of such requirements on the willingness of insurers to offer Medicare+Choice MSA plans and options for modifying encounter data reporting requirements to accommodate such plans.

“(E) Differences in the ability of Medicare+Choice organizations to report encounter data, and the po-

tential for adverse competitive impacts on group and staff model health maintenance organizations or other integrated providers of care based on data reporting capabilities.

“(2) REPORT.—Not later than January 1, 2001, the Secretary shall submit a report to Congress on the study conducted under this subsection, together with any recommendations for legislation that the Secretary determines to be appropriate as a result of such study.”

SPECIAL RULE FOR 2001

Pub. L. 106-113, div. B, §1000(a)(6) [title V, §514(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A-384, provided that: “In providing for the publication of information under section 1853(b)(4) of the Social Security Act (42 U.S.C. 1395w-23(b)(4)), as added by subsection (a), in 2001, the Secretary of Health and Human Services shall also include the information described in such section for 1998, as well as for 1999.”

DEVELOPMENT OF SPECIAL PAYMENT RULES UNDER MEDICARE+CHOICE PROGRAM FOR FRAIL ELDERLY ENROLLED IN SPECIALIZED PROGRAMS

Pub. L. 106-113, div. B, §1000(a)(6) [title V, §552(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A-392, provided that:

“(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the development of a payment methodology under the Medicare+Choice program for frail elderly Medicare+Choice beneficiaries enrolled in a Medicare+Choice plan under a specialized program for the frail elderly that—

“(A) accounts for the prevalence, mix, and severity of chronic conditions among such frail elderly Medicare+Choice beneficiaries;

“(B) includes medical diagnostic factors from all provider settings (including hospital and nursing facility settings); and

“(C) includes functional indicators of health status and such other factors as may be necessary to achieve appropriate payments for plans serving such beneficiaries.

“(2) REPORT.—Not later than 1 year after the date of the enactment of this Act [Nov. 29, 1999], the Commission shall submit a report to Congress on the study conducted under paragraph (1), together with any recommendations for legislation that the Commission determines to be appropriate as a result of such study.”

PUBLICATION OF NEW CAPITATION RATES

Pub. L. 105-33, title IV, §4002(i), Aug. 5, 1997, 111 Stat. 330, provided that: “Not later than 4 weeks after the date of the enactment of this Act [Aug. 5, 1997], the Secretary of Health and Human Services shall announce the annual Medicare+Choice capitation rates for 1998 under section 1853(b) of the Social Security Act [subsec. (b) of this section].”

MEDICARE+CHOICE COMPETITIVE PRICING DEMONSTRATION PROJECT

Pub. L. 105-33, title IV, §§4011, 4012, Aug. 5, 1997, 111 Stat. 334-336, as amended by Pub. L. 106-113, div. B, §1000(a)(6) [title V, §533], Nov. 29, 1999, 113 Stat. 1536, 1501A-389, provided that:

“SEC. 4011. MEDICARE PREPAID COMPETITIVE PRICING DEMONSTRATION PROJECT.

“(a) ESTABLISHMENT OF PROJECT.—

“(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary of Health and Human Services (in this subchapter [subchapter A (§§ 4011-4012) of chapter 2 of subtitle A of title IV of Pub. L. 105-33] referred to as the ‘Secretary’) shall establish a demonstration project (in this subchapter referred to as the ‘project’) under which payments to Medicare+Choice organizations in medicare payment areas in which the project is being conducted are determined in accordance with a competitive pricing methodology established under this subchapter.

“(2) DELAY IN IMPLEMENTATION.—The Secretary shall not implement the project until January 1, 2002,

or, if later, 6 months after the date the Competitive Pricing Advisory Committee has submitted to Congress a report on each of the following topics:

“(A) INCORPORATION OF ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM INTO PROJECT.—What changes would be required in the project to feasibly incorporate the original medicare fee-for-service program into the project in the areas in which the project is operational.

“(B) QUALITY ACTIVITIES.—The nature and extent of the quality reporting and monitoring activities that should be required of plans participating in the project, the estimated costs that plans will incur as a result of these requirements, and the current ability of the Health Care Financing Administration to collect and report comparable data, sufficient to support comparable quality reporting and monitoring activities with respect to beneficiaries enrolled in the original medicare fee-for-service program generally.

“(C) RURAL PROJECT.—The current viability of initiating a project site in a rural area, given the site specific budget neutrality requirements of the project under subsection (g), and insofar as the Committee decides that the addition of such a site is not viable, recommendations on how the project might best be changed so that such a site is viable.

“(D) BENEFIT STRUCTURE.—The nature and extent of the benefit structure that should be required of plans participating in the project, the rationale for such benefit structure, the potential implications that any benefit standardization requirement may have on the number of plan choices available to a beneficiary in an area designated under the project, the potential implications of requiring participating plans to offer variations on any standardized benefit package the committee might recommend, such that a beneficiary could elect to pay a higher percentage of out-of-pocket costs in exchange for a lower premium (or premium rebate as the case may be), and the potential implications of expanding the project (in conjunction with the potential inclusion of the original medicare fee-for-service program) to require medicare supplemental insurance plans operating in an area designated under the project to offer a coordinated and comparable standardized benefit package.

“(3) CONFORMING DEADLINES.—Any dates specified in the succeeding provisions of this section shall be delayed (as specified by the Secretary) in a manner consistent with the delay effected under paragraph (2).

“(b) DESIGNATION OF 7 MEDICARE PAYMENT AREAS COVERED BY PROJECT.—

“(1) IN GENERAL.—The Secretary shall designate, in accordance with the recommendations of the Competitive Pricing Advisory Committee under paragraphs (2) and (3), medicare payment areas as areas in which the project under this subchapter will be conducted. In this section, the term ‘Competitive Pricing Advisory Committee’ means the Competitive Pricing Advisory Committee established under section 4012(a).

“(2) INITIAL DESIGNATION OF 4 AREAS.—

“(A) IN GENERAL.—The Competitive Pricing Advisory Committee shall recommend to the Secretary, consistent with subparagraph (B), the designation of 4 specific areas as medicare payment areas to be included in the project. Such recommendations shall be made in a manner so as to ensure that payments under the project in 2 such areas will begin on January 1, 1999, and in 2 such areas will begin on January 1, 2000.

“(B) LOCATION OF DESIGNATION.—Of the 4 areas recommended under subparagraph (A), 3 shall be in urban areas and 1 shall be in a rural area.

“(3) DESIGNATION OF ADDITIONAL 3 AREAS.—Not later than December 31, 2001, the Competitive Pricing Advisory Committee may recommend to the Secretary the designation of up to 3 additional, specific medicare payment areas to be included in the project.

“(c) PROJECT IMPLEMENTATION.—

“(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall for each medicare payment area designated under subsection (b)—

“(A) in accordance with the recommendations of the Competitive Pricing Advisory Committee—

“(i) establish the benefit design among plans offered in such area,

“(ii) structure the method for selecting plans offered in such area; and

“(iii) establish beneficiary premiums for plans offered in such area in a manner such that a beneficiary who enrolls in an offered plan the per capita bid for which is less than the standard per capita government contribution (as established by the competitive pricing methodology established for such area) may, at the plan's election, be offered a rebate of some or all of the medicare part B premium that such individual must otherwise pay in order to participate in a Medicare+Choice plan under the Medicare+Choice program; and

“(B) in consultation with such Committee—

“(i) establish methods for setting the price to be paid to plans, including, if the Secretaries determine appropriate, the rewarding and penalizing of Medicare+Choice plans in the area on the basis of the attainment of, or failure to attain, applicable quality standards, and

“(ii) provide for the collection of plan information (including information concerning quality and access to care), the dissemination of information, and the methods of evaluating the results of the project.

“(2) CONSULTATION.—The Secretary shall take into account the recommendations of the area advisory committee established in section 4012(b), in implementing a project design for any area, except that no modifications may be made in the project design without consultation with the Competitive Pricing Advisory Committee. In no case may the Secretary change the designation of an area based on recommendations of any area advisory committee.

“(d) MONITORING AND REPORT.—

“(1) MONITORING IMPACT.—Taking into consideration the recommendations of the Competitive Pricing Advisory Committee and the area advisory committees, the Secretary shall closely monitor and measure the impact of the project in the different areas on the price and quality of, and access to, medicare covered services, choice of health plans, changes in enrollment, and other relevant factors.

“(2) REPORT.—Not later than December 31, 2002, the Secretary shall submit to Congress a report on the progress under the project under this subchapter, including a comparison of the matters monitored under paragraph (1) among the different designated areas. The report may include any legislative recommendations for extending the project to the entire medicare population.

“(e) WAIVER AUTHORITY.—The Secretary of Health and Human Services may waive such requirements of title XVIII of the Social Security Act [this subchapter] (as amended by this Act) as may be necessary for the purposes of carrying out the project.

“(f) RELATIONSHIP TO OTHER AUTHORITY.—Except pursuant to this subchapter, the Secretary of Health and Human Services may not conduct or continue any medicare demonstration project relating to payment of health maintenance organizations, Medicare+Choice organizations, or similar prepaid managed care entities on the basis of a competitive bidding process or pricing system described in subsection (a).

“(g) NO ADDITIONAL COSTS TO MEDICARE PROGRAM.—The aggregate payments to Medicare+Choice organizations under the project for any designated area for a fiscal year may not exceed the aggregate payments to such organizations that would have been made under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 4001 [enacting this part

and redesignating former part C of this subchapter as part D], if the project had not been conducted.

“(h) DEFINITIONS.—Any term used in this subchapter which is also used in part C of title XVIII of the Social Security Act [this part], as amended by section 4001, shall have the same meaning as when used in such part.

“SEC. 4012. ADVISORY COMMITTEES.

“(a) COMPETITIVE PRICING ADVISORY COMMITTEE.—

“(1) IN GENERAL.—Before implementing the project under this subchapter [subchapter A (§§ 4011–4012) of chapter 2 of subtitle A of title IV of Pub. L. 105–33], the Secretary shall appoint the Competitive Pricing Advisory Committee, including independent actuaries, individuals with expertise in competitive health plan pricing, and an employee of the Office of Personnel Management with expertise in the administration of the Federal Employees Health Benefit Program, to make recommendations to the Secretary concerning the designation of areas for inclusion in the project and appropriate research design for implementing the project.

“(2) INITIAL RECOMMENDATIONS.—The Competitive Pricing Advisory Committee initially shall submit recommendations regarding the area selection, benefit design among plans offered, structuring choice among health plans offered, methods for setting the price to be paid to plans, collection of plan information (including information concerning quality and access to care), information dissemination, and methods of evaluating the results of the project.

“(3) QUALITY RECOMMENDATION.—The Competitive Pricing Advisory Committee shall study and make recommendations regarding the feasibility of providing financial incentives and penalties to plans operating under the project that meet, or fail to meet, applicable quality standards.

“(4) ADVICE DURING IMPLEMENTATION.—Upon implementation of the project, the Competitive Pricing Advisory Committee shall continue to advise the Secretary on the application of the design in different areas and changes in the project based on experience with its operations.

“(5) SUNSET.—The Competitive Pricing Advisory Committee shall terminate on December 31, 2004.

“(b) APPOINTMENT OF AREA ADVISORY COMMITTEE.—Upon the designation of an area for inclusion in the project, the Secretary shall appoint an area advisory committee, composed of representatives of health plans, providers, and medicare beneficiaries in the area, to advise the Secretary concerning how the project will be implemented in the area. Such advice may include advice concerning the marketing and pricing of plans in the area and other salient factors. The duration of such a committee for an area shall be for the duration of the operation of the project in the area.

“(c) SPECIAL APPLICATION.—Notwithstanding section 9(c) of the Federal Advisory Committee Act (5 U.S.C. App.), the Competitive Pricing Advisory Commission and any area advisory committee (described in subsection (b)) may meet as soon as the members of the commission or committee, respectively, are appointed.”

§ 1395w-24. Premiums and bid amounts

(a) Submission of proposed premiums, bid amounts, and related information

(1) In general

(A) Initial submission

Not later than the second Monday in September of 2002, 2003, and 2004 (or the first Monday in June of each subsequent year), each MA organization shall submit to the Secretary, in a form and manner specified by the Secretary and for each MA plan for the service area (or segment of such an area if permitted under subsection (h) of this sec-

tion) in which it intends to be offered in the following year the following:

- (i) The information described in paragraph (2), (3), (4), or (6)(A) for the type of plan and year involved.
- (ii) The plan type for each plan.
- (iii) The enrollment capacity (if any) in relation to the plan and area.

(B) Beneficiary rebate information

In the case of a plan required to provide a monthly rebate under subsection (b)(1)(C) of this section for a year, the MA organization offering the plan shall submit to the Secretary, in such form and manner and at such time as the Secretary specifies, information on—

- (i) the manner in which such rebate will be provided under clause (ii) of such subsection; and
- (ii) the MA monthly prescription drug beneficiary premium (if any) and the MA monthly supplemental beneficiary premium (if any).

(C) Paperwork reduction for offering of MA regional plans nationally or in multi-region areas

The Secretary shall establish requirements for information submission under this subsection in a manner that promotes the offering of MA regional plans in more than one region (including all regions) through the filing of consolidated information.

(2) Information required for coordinated care plans before 2006

For a Medicare+Choice plan described in section 1395w-21(a)(2)(A) of this title for a year before 2006, the information described in this paragraph is as follows:

(A) Basic (and additional) benefits

For benefits described in section 1395w-22(a)(1)(A) of this title—

- (i) the adjusted community rate (as defined in subsection (f)(3) of this section);
- (ii) the Medicare+Choice monthly basic beneficiary premium (as defined in subsection (b)(2)(A) of this section);
- (iii) a description of deductibles, coinsurance, and copayments applicable under the plan and the actuarial value of such deductibles, coinsurance, and copayments, described in subsection (e)(1)(A) of this section; and
- (iv) if required under subsection (f)(1) of this section, a description of the additional benefits to be provided pursuant to such subsection and the value determined for such proposed benefits under such subsection.

(B) Supplemental benefits

For benefits described in section 1395w-22(a)(3) of this title—

- (i) the adjusted community rate (as defined in subsection (f)(3) of this section);
- (ii) the Medicare+Choice monthly supplemental beneficiary premium (as defined in subsection (b)(2)(B) of this section); and
- (iii) a description of deductibles, coinsurance, and copayments applicable under the

plan and the actuarial value of such deductibles, coinsurance, and copayments, described in subsection (e)(2) of this section.

(3) Requirements for MSA plans

For an MSA plan for any year, the information described in this paragraph is as follows:

(A) Basic (and additional) benefits

For benefits described in section 1395w-22(a)(1)(A) of this title, the amount of the Medicare+Choice monthly MSA premium.

(B) Supplemental benefits

For benefits described in section 1395w-22(a)(3) of this title, the amount of the Medicare+Choice monthly supplementary beneficiary premium.

(4) Requirements for private fee-for-service plans before 2006

For a Medicare+Choice plan described in section 1395w-21(a)(2)(C) of this title for benefits described in section 1395w-22(a)(1)(A) of this title for a year before 2006, the information described in this paragraph is as follows:

(A) Basic (and additional) benefits

For benefits described in section 1395w-22(a)(1)(A) of this title—

- (i) the adjusted community rate (as defined in subsection (f)(3) of this section);
- (ii) the amount of the Medicare+Choice monthly basic beneficiary premium;
- (iii) a description of the deductibles, coinsurance, and copayments applicable under the plan, and the actuarial value of such deductibles, coinsurance, and copayments, as described in subsection (e)(4)(A) of this section; and
- (iv) if required under subsection (f)(1) of this section, a description of the additional benefits to be provided pursuant to such subsection and the value determined for such proposed benefits under such subsection.

(B) Supplemental benefits

For benefits described in section 1395w-22(a)(3) of this title, the amount of the Medicare+Choice monthly supplemental beneficiary premium (as defined in subsection (b)(2)(B) of this section).

(5) Review

(A) In general

Subject to subparagraph (B), the Secretary shall review the adjusted community rates, the amounts of the basic and supplemental premiums, and values filed under paragraphs (2) and (4) of this subsection and shall approve or disapprove such rates, amounts, and values so submitted. The Chief Actuary of the Centers for Medicare & Medicaid Services shall review the actuarial assumptions and data used by the Medicare+Choice organization with respect to such rates, amounts, and values so submitted to determine the appropriateness of such assumptions and data.

(B) Exception

The Secretary shall not review, approve, or disapprove the amounts submitted under

paragraph (3) or, in the case of an MA private fee-for-service plan, subparagraphs (A)(ii) and (B) of paragraph (4).

(C) Rejection of bids

(i) In general

Nothing in this section shall be construed as requiring the Secretary to accept any or every bid submitted by an MA organization under this subsection.

(ii) Authority to deny bids that propose significant increases in cost sharing or decreases in benefits

The Secretary may deny a bid submitted by an MA organization for an MA plan if it proposes significant increases in cost sharing or decreases in benefits offered under the plan.

(6) Submission of bid amounts by MA organizations beginning in 2006

(A) Information to be submitted

For an MA plan (other than an MSA plan) for a plan year beginning on or after January 1, 2006, the information described in this subparagraph is as follows:

(i) The monthly aggregate bid amount for the provision of all items and services under the plan, which amount shall be based on average revenue requirements (as used for purposes of section 300e-1(8) of this title) in the payment area for an enrollee with a national average risk profile for the factors described in section 1395w-23(a)(1)(C) of this title (as specified by the Secretary).

(ii) The proportions of such bid amount that are attributable to—

(I) the provision of benefits under the original medicare fee-for-service program option (as defined in section 1395w-22(a)(1)(B) of this title);

(II) the provision of basic prescription drug coverage; and

(III) the provision of supplemental health care benefits.

(iii) The actuarial basis for determining the amount under clause (i) and the proportions described in clause (ii) and such additional information as the Secretary may require to verify such actuarial bases and the projected number of enrollees in each MA local area.

(iv) A description of deductibles, coinsurance, and copayments applicable under the plan and the actuarial value of such deductibles, coinsurance, and copayments, described in subsection (e)(4)(A) of this section.

(v) With respect to qualified prescription drug coverage, the information required under section 1395w-104 of this title, as incorporated under section 1395w-111(b)(2) of this title, with respect to such coverage.

In the case of a specialized MA plan for special needs individuals, the information described in this subparagraph is such information as the Secretary shall specify.

(B) Acceptance and negotiation of bid amounts

(i) Authority

Subject to clauses (iii) and (iv), the Secretary has the authority to negotiate regarding monthly bid amounts submitted under subparagraph (A) (and the proportions described in subparagraph (A)(ii)), including supplemental benefits provided under subsection (b)(1)(C)(ii)(I) of this section and in exercising such authority the Secretary shall have authority similar to the authority of the Director of the Office of Personnel Management with respect to health benefits plans under chapter 89 of title 5.

(ii) Application of FEHBP standard

Subject to clause (iv), the Secretary may only accept such a bid amount or proportion if the Secretary determines that such amount and proportions are supported by the actuarial bases provided under subparagraph (A) and reasonably and equitably reflects the revenue requirements (as used for purposes of section 300e-1(8) of this title) of benefits provided under that plan.

(iii) Noninterference

In order to promote competition under this part and part D of this subchapter and in carrying out such parts, the Secretary may not require any MA organization to contract with a particular hospital, physician, or other entity or individual to furnish items and services under this subchapter or require a particular price structure for payment under such a contract to the extent consistent with the Secretary's authority under this part.

(iv) Exception

In the case of a plan described in section 1395w-21(a)(2)(C) of this title, the provisions of clauses (i) and (ii) shall not apply and the provisions of paragraph (5)(B), prohibiting the review, approval, or disapproval of amounts described in such paragraph, shall apply to the negotiation and rejection of the monthly bid amounts and the proportions referred to in subparagraph (A).

(b) Monthly premium charged

(1) In general

(A) Rule for other than MSA plans

Subject to the rebate under subparagraph (C), the monthly amount (if any) of the premium charged to an individual enrolled in a Medicare+Choice plan (other than an MSA plan) offered by a Medicare+Choice organization shall be equal to the sum of the Medicare+Choice monthly basic beneficiary premium, the Medicare+Choice monthly supplementary beneficiary premium (if any), and, if the plan provides qualified prescription drug coverage, the MA monthly prescription drug beneficiary premium.

(B) MSA plans

The monthly amount of the premium charged to an individual enrolled in an MSA

plan offered by a Medicare+Choice organization shall be equal to the Medicare+Choice monthly supplemental beneficiary premium (if any).

(C) Beneficiary rebate rule

(i) Requirement

The MA plan shall provide to the enrollee a monthly rebate equal to 75 percent (or the applicable rebate percentage specified in clause (iii) in the case of plan years beginning on or after January 1, 2012) of the average per capita savings (if any) described in paragraph (3)(C) or (4)(C), as applicable to the plan and year involved.

(ii) Form of rebate for plan years before 2012

For plan years before 2012, a rebate required under this subparagraph shall be provided through the application of the amount of the rebate toward one or more of the following:

(I) Provision of supplemental health care benefits and payment for premium for supplemental benefits

The provision of supplemental health care benefits described in section 1395w-22(a)(3) of this title in a manner specified under the plan, which may include the reduction of cost-sharing otherwise applicable as well as additional health care benefits which are not benefits under the original medicare fee-for-service program option, or crediting toward an MA monthly supplemental beneficiary premium (if any).

(II) Payment for premium for prescription drug coverage

Crediting toward the MA monthly prescription drug beneficiary premium.

(III) Payment toward part B premium

Crediting toward the premium imposed under part B of this subchapter (determined without regard to the application of subsections (b), (h), and (i) of section 1395r of this title).

(iii) Applicable rebate percentage

The applicable rebate percentage specified in this clause for a plan for a year, based on the system under section 1395w-23(o)(4)(A), is the sum of—

(I) the product of the old phase-in proportion for the year under clause (iv) and 75 percent; and

(II) the product of the new phase-in proportion for the year under clause (iv) and the final applicable rebate percentage under clause (v).

(iv) Old and new phase-in proportions

For purposes of clause (iv)—

(I) for 2012, the old phase-in proportion is $\frac{2}{3}$ and the new phase-in proportion is $\frac{1}{3}$;

(II) for 2013, the old phase-in proportion is $\frac{1}{3}$ and the new phase-in proportion is $\frac{2}{3}$; and

(III) for 2014 and any subsequent year, the old phase-in proportion is 0 and the new phase-in proportion is 1.

(v) Final applicable rebate percentage

Subject to clause (vi), the final applicable rebate percentage under this clause is—

(I) in the case of a plan with a quality rating under such system of at least 4.5 stars, 70 percent;

(II) in the case of a plan with a quality rating under such system of at least 3.5 stars and less than 4.5 stars, 65 percent; and

(III) in the case of a plan with a quality rating under such system of less than 3.5 stars, 50 percent.

(vi) Treatment of low enrollment and new plans

For purposes of clause (v)—

(I) for 2012, in the case of a plan described in subclause (I) of subsection (o)(3)(A)(ii),¹ the plan shall be treated as having a rating of 4.5 stars; and

(II) for 2012 or a subsequent year, in the case of a new MA plan (as defined under subclause (III) of subsection (o)(3)(A)(iii))² that is treated as a qualifying plan pursuant to subclause (I) of such subsection, the plan shall be treated as having a rating of 3.5 stars.

(vii) Disclosure relating to rebates

The plan shall disclose to the Secretary information on the form and amount of the rebate provided under this subparagraph or the actuarial value in the case of supplemental health care benefits.

(viii) Application of part B premium reduction

Insofar as an MA organization elects to provide a rebate under this subparagraph under a plan as a credit toward the part B premium under clause (ii)(III), the Secretary shall apply such credit to reduce the premium under section 1395r of this title of each enrollee in such plan as provided in section 1395s(i) of this title.

(2) Premium and bid terminology defined

For purposes of this part:

(A) MA monthly basic beneficiary premium

The term “MA monthly basic beneficiary premium” means, with respect to an MA plan—

(i) described in section 1395w-23(a)(1)(B)(i) of this title (relating to plans providing rebates), zero; or

(ii) described in section 1395w-23(a)(1)(B)(ii) of this title, the amount (if any) by which the unadjusted MA statutory non-drug monthly bid amount (as defined in subparagraph (E)) exceeds the applicable unadjusted MA area-specific non-drug monthly benchmark amount (as defined in section 1395w-23(j) of this title).

¹So in original. Probably means subclause (I) of section 1395w-23(o)(3)(A)(ii) of this title.

²So in original. Probably means subclause (II) of section 1395w-23(o)(3)(A)(iii) of this title.

(B) MA monthly prescription drug beneficiary premium

The term “MA monthly prescription drug beneficiary premium” means, with respect to an MA plan, the base beneficiary premium (as determined under section 1395w-113(a)(2) of this title and as adjusted under section 1395w-113(a)(1)(B) of this title), less the amount of rebate credited toward such amount under subsection (b)(1)(C)(ii)(II) of this section.

(C) MA monthly supplemental beneficiary premium

(i) In general

The term “MA monthly supplemental beneficiary premium” means, with respect to an MA plan, the portion of the aggregate monthly bid amount submitted under clause (i) of subsection (a)(6)(A) of this section for the year that is attributable under clause (ii)(III) of such subsection to the provision of supplemental health care benefits, less the amount of rebate credited toward such portion under subsection (b)(1)(C)(ii)(I) of this section.

(ii) Application of MA monthly supplementary beneficiary premium

For plan years beginning on or after January 1, 2012, any MA monthly supplementary beneficiary premium charged to an individual enrolled in an MA plan shall be used for the purposes, and in the priority order, described in subclauses (I) through (III) of paragraph (1)(C)(iii).³

(D) Medicare+Choice monthly MSA premium

The term “Medicare+Choice monthly MSA premium” means, with respect to a Medicare+Choice plan, the amount of such premium filed under subsection (a)(3)(A) of this section for the plan.

(E) Unadjusted MA statutory non-drug monthly bid amount

The term “unadjusted MA statutory non-drug monthly bid amount” means the portion of the bid amount submitted under clause (i) of subsection (a)(6)(A) of this section for the year that is attributable under clause (ii)(I) of such subsection to the provision of benefits under the original medicare fee-for-service program option (as defined in section 1395w-22(a)(1)(B) of this title).

(3) Computation of average per capita monthly savings for local plans

For purposes of paragraph (1)(C)(i), the average per capita monthly savings referred to in such paragraph for an MA local plan and year is computed as follows:

(A) Determination of statewide average risk adjustment for local plans

(i) In general

Subject to clause (iii), the Secretary shall determine, at the same time rates are promulgated under section 1395w-23(b)(1) of this title (beginning with

2006) for each State, the average of the risk adjustment factors to be applied under section 1395w-23(a)(1)(C) of this title to payment for enrollees in that State for MA local plans.

(ii) Treatment of States for first year in which local plan offered

In the case of a State in which no MA local plan was offered in the previous year, the Secretary shall estimate such average. In making such estimate, the Secretary may use average risk adjustment factors applied to comparable States or applied on a national basis.

(iii) Authority to determine risk adjustment for areas other than States

The Secretary may provide for the determination and application of risk adjustment factors under this subparagraph on the basis of areas other than States or on a plan-specific basis.

(B) Determination of risk adjusted benchmark and risk-adjusted bid for local plans

For each MA plan offered in a local area in a State, the Secretary shall—

(i) adjust the applicable MA area-specific non-drug monthly benchmark amount (as defined in section 1395w-23(j)(1) of this title) for the area by the average risk adjustment factor computed under subparagraph (A); and

(ii) adjust the unadjusted MA statutory non-drug monthly bid amount by such applicable average risk adjustment factor.

(C) Determination of average per capita monthly savings

The average per capita monthly savings described in this subparagraph for an MA local plan is equal to the amount (if any) by which—

(i) the risk-adjusted benchmark amount computed under subparagraph (B)(i); exceeds

(ii) the risk-adjusted bid computed under subparagraph (B)(ii).

(4) Computation of average per capita monthly savings for regional plans

For purposes of paragraph (1)(C)(i), the average per capita monthly savings referred to in such paragraph for an MA regional plan and year is computed as follows:

(A) Determination of regionwide average risk adjustment for regional plans

(i) In general

The Secretary shall determine, at the same time rates are promulgated under section 1395w-23(b)(1) of this title (beginning with 2006) for each MA region the average of the risk adjustment factors to be applied under section 1395w-23(a)(1)(C) of this title to payment for enrollees in that region for MA regional plans.

(ii) Treatment of regions for first year in which regional plan offered

In the case of an MA region in which no MA regional plan was offered in the pre-

³ See References in Text note below.

vious year, the Secretary shall estimate such average. In making such estimate, the Secretary may use average risk adjustment factors applied to comparable regions or applied on a national basis.

(iii) Authority to determine risk adjustment for areas other than regions

The Secretary may provide for the determination and application of risk adjustment factors under this subparagraph on the basis of areas other than MA regions or on a plan-specific basis.

(B) Determination of risk-adjusted benchmark and risk-adjusted bid for regional plans

For each MA regional plan offered in a region, the Secretary shall—

(i) adjust the applicable MA area-specific non-drug monthly benchmark amount (as defined in section 1395w-23(j)(2) of this title) for the region by the average risk adjustment factor computed under subparagraph (A); and

(ii) adjust the unadjusted MA statutory non-drug monthly bid amount by such applicable average risk adjustment factor.

(C) Determination of average per capita monthly savings

The average per capita monthly savings described in this subparagraph for an MA regional plan is equal to the amount (if any) by which—

(i) the risk-adjusted benchmark amount computed under subparagraph (B)(i); exceeds

(ii) the risk-adjusted bid computed under subparagraph (B)(ii).

(c) Uniform premium and bid amounts

Except as permitted under section 1395w-27(i) of this title, the MA monthly bid amount submitted under subsection (a)(6) of this section, the amounts of the MA monthly basic, prescription drug, and supplemental beneficiary premiums, and the MA monthly MSA premium charged under subsection (b) of this section of an MA organization under this part may not vary among individuals enrolled in the plan.

(d) Terms and conditions of imposing premiums

(1) In general

Each Medicare+Choice organization shall permit the payment of Medicare+Choice monthly basic, prescription drug, and supplemental beneficiary premiums on a monthly basis, may terminate election of individuals for a Medicare+Choice plan for failure to make premium payments only in accordance with section 1395w-21(g)(3)(B)(i) of this title, and may not provide for cash or other monetary rebates as an inducement for enrollment or otherwise.

(2) Beneficiary's option of payment through withholding from social security payment or use of electronic funds transfer mechanism

In accordance with regulations, an MA organization shall permit each enrollee, at the enrollee's option, to make payment of premiums

(if any) under this part to the organization through—

(A) withholding from benefit payments in the manner provided under section 1395s of this title with respect to monthly premiums under section 1395r of this title;

(B) an electronic funds transfer mechanism (such as automatic charges of an account at a financial institution or a credit or debit card account); or

(C) such other means as the Secretary may specify, including payment by an employer or under employment-based retiree health coverage (as defined in section 1395w-132(c)(1) of this title) on behalf of an employee or former employee (or dependent).

All premium payments that are withheld under subparagraph (A) shall be credited to the appropriate Trust Fund (or Account thereof), as specified by the Secretary, under this subchapter and shall be paid to the MA organization involved. No charge may be imposed under an MA plan with respect to the election of the payment option described in subparagraph (A). The Secretary shall consult with the Commissioner of Social Security and the Secretary of the Treasury regarding methods for allocating premiums withheld under subparagraph (A) among the appropriate Trust Funds and Account.

(3) Information necessary for collection

In order to carry out paragraph (2)(A) with respect to an enrollee who has elected such paragraph to apply, the Secretary shall transmit to the Commissioner of Social Security—

(A) by the beginning of each year, the name, social security account number, consolidated monthly beneficiary premium described in paragraph (4) owed by such enrollee for each month during the year, and other information determined appropriate by the Secretary, in consultation with the Commissioner of Social Security; and

(B) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.

(4) Consolidated monthly beneficiary premium

In the case of an enrollee in an MA plan, the Secretary shall provide a mechanism for the consolidation of—

(A) the MA monthly basic beneficiary premium (if any);

(B) the MA monthly supplemental beneficiary premium (if any); and

(C) the MA monthly prescription drug beneficiary premium (if any).

(e) Limitation on enrollee liability

(1) For basic and additional benefits before 2006

For periods before 2006, in no event may—

(A) the Medicare+Choice monthly basic beneficiary premium (multiplied by 12) and the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with a Medicare+Choice plan described in

section 1395w-21(a)(2)(A) of this title of an organization with respect to required benefits described in section 1395w-22(a)(1)(A) of this title and additional benefits (if any) required under subsection (f)(1)(A) of this section for a year, exceed

(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter if they were not members of a Medicare+Choice organization for the year.

(2) For supplemental benefits before 2006

For periods before 2006, if the Medicare+Choice organization provides to its members enrolled under this part in a Medicare+Choice plan described in section 1395w-21(a)(2)(A) of this title with respect to supplemental benefits described in section 1395w-22(a)(3) of this title, the sum of the Medicare+Choice monthly supplemental beneficiary premium (multiplied by 12) charged and the actuarial value of its deductibles, coinsurance, and copayments charged with respect to such benefits may not exceed the adjusted community rate for such benefits (as defined in subsection (f)(3) of this section).

(3) Determination on other basis

If the Secretary determines that adequate data are not available to determine the actuarial value under paragraph (1)(A), (2), or (4), the Secretary may determine such amount with respect to all individuals in same geographic area, the State, or in the United States, eligible to enroll in the Medicare+Choice plan involved under this part or on the basis of other appropriate data.

(4) Special rule for private fee-for-service plans and for basic benefits beginning in 2006

With respect to a Medicare+Choice private fee-for-service plan (other than a plan that is an MSA plan) and for periods beginning with 2006, with respect to an MA plan described in section 1395w-21(a)(2)(A) of this title, in no event may—

(A) the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with such a plan of an organization with respect to benefits under the original medicare fee-for-service program option, exceed

(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable with respect to such benefits on average to individuals entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter if they were not members of a Medicare+Choice organization for the year.

(f) Requirement for additional benefits before 2006

(1) Requirement

(A) In general

For years before 2006, each Medicare+Choice organization (in relation to a Medicare+Choice plan, other than an MSA

plan, it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the plan for a contract year, subject to the succeeding provisions of this subsection, the organization shall provide to individuals such additional benefits (as the organization may specify) in a value which the Secretary determines is at least equal to the adjusted excess amount (as defined in subparagraph (C)).

(B) Excess amount

For purposes of this paragraph, the “excess amount”, for an organization for a plan, is the amount (if any) by which—

(i) the average of the capitation payments made to the organization under section 1395w-23 of this title for the plan at the beginning of contract year, exceeds

(ii) the actuarial value of the required benefits described in section 1395w-22(a)(1)(A) of this title under the plan for individuals under this part, as determined based upon an adjusted community rate described in paragraph (3) (as reduced for the actuarial value of the coinsurance, copayments, and deductibles under parts A and B of this subchapter).

(C) Adjusted excess amount

For purposes of this paragraph, the “adjusted excess amount”, for an organization for a plan, is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (2).

(D) Uniform application

This paragraph shall be applied uniformly for all enrollees for a plan.

(E) Premium reductions

(i) In general

Subject to clause (ii), as part of providing any additional benefits required under subparagraph (A), a Medicare+Choice organization may elect a reduction in its payments under section 1395w-23(a)(1)(A) of this title with respect to a Medicare+Choice plan and the Secretary shall apply such reduction to reduce the premium under section 1395r of this title of each enrollee in such plan as provided in section 1395s(i) of this title.

(ii) Amount of reduction

The amount of the reduction under clause (i) with respect to any enrollee in a Medicare+Choice plan—

(I) may not exceed 125 percent of the premium described under section 1395r(a)(3) of this title; and

(II) shall apply uniformly to each enrollee of the Medicare+Choice plan to which such reduction applies.

(F) Construction

Nothing in this subsection shall be construed as preventing a Medicare+Choice organization from providing supplemental benefits (described in section 1395w-22(a)(3) of this title) that are in addition to the health care benefits otherwise required to be pro-

vided under this paragraph and from imposing a premium for such supplemental benefits.

(2) Stabilization fund

A Medicare+Choice organization may provide that a part of the value of an excess amount described in paragraph (1) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to stabilize and prevent undue fluctuations in the additional benefits offered in those subsequent periods by the organization in accordance with such paragraph. Any of such value of the amount reserved which is not provided as additional benefits described in paragraph (1)(A) to individuals electing the Medicare+Choice plan of the organization in accordance with such paragraph prior to the end of such periods, shall revert for the use of such trust funds.

(3) Adjusted community rate

For purposes of this subsection, subject to paragraph (4), the term “adjusted community rate” for a service or services means, at the election of a Medicare+Choice organization, either—

(A) the rate of payment for that service or services which the Secretary annually determines would apply to an individual electing a Medicare+Choice plan under this part if the rate of payment were determined under a “community rating system” (as defined in section 300e-1(8) of this title, other than subparagraph (C)), or

(B) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to such an individual, as the Secretary annually estimates is attributable to that service or services,

but adjusted for differences between the utilization characteristics of the individuals electing coverage under this part and the utilization characteristics of the other enrollees with the plan (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of individuals selecting other Medicare+Choice coverage, or Medicare+Choice eligible individuals in the area, in the State, or in the United States, eligible to elect Medicare+Choice coverage under this part and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

(4) Determination based on insufficient data

For purposes of this subsection, if the Secretary finds that there is insufficient enrollment experience to determine an average of the capitation payments to be made under this part at the beginning of a contract period or to determine (in the case of a newly operated provider-sponsored organization or other new organization) the adjusted community rate for the organization, the Secretary may determine such an average based on the enrollment

experience of other contracts entered into under this part and may determine such a rate using data in the general commercial marketplace.

(g) Prohibition of State imposition of premium taxes

No State may impose a premium tax or similar tax with respect to payments to Medicare+Choice organizations under section 1395w-23 of this title or premiums paid to such organizations under this part.

(h) Permitting use of segments of service areas

The Secretary shall permit a Medicare+Choice organization to elect to apply the provisions of this section uniformly to separate segments of a service area (rather than uniformly to an entire service area) as long as such segments are composed of one or more Medicare+Choice payment areas.

(Aug. 14, 1935, ch. 531, title XVIII, § 1854, as added Pub. L. 105-33, title IV, § 4001, Aug. 5, 1997, 111 Stat. 308; amended Pub. L. 106-113, div. B, § 1000(a)(6) [title III, § 321(k)(6)(C), title V, §§ 515(a), 516(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A-367, 1501A-384; Pub. L. 106-554, § 1(a)(6) [title VI, §§ 606(a)(1), 622(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A-557, 2763A-566; Pub. L. 107-188, title V, § 532(b)(1), June 12, 2002, 116 Stat. 696; Pub. L. 108-173, title II, §§ 222(a)(1), (b), (c), (g), 232(b), title IX, § 900(e)(1)(H), Dec. 8, 2003, 117 Stat. 2193, 2196, 2199, 2203, 2208, 2371; Pub. L. 111-148, title III, §§ 3201(a)(2)(B), (c)-(d)(2), (e)(2)(A)(v), 3202(b)(1), (3), 3209(a), Mar. 23, 2010, 124 Stat. 444, 447, 454, 455, 460; Pub. L. 111-152, title I, § 1102(a), (d), Mar. 30, 2010, 124 Stat. 1040, 1045.)

REFERENCES IN TEXT

Cl. (iii) of par. (1)(C), referred to in subsec. (b)(2)(C)(ii), was struck out and a new cl. (iii) was added by Pub. L. 111-152, § 1102(d)(2). See 2010 Amendment note below. As so amended, par. (1)(C)(iii) no longer relates to purposes of rebates and no longer contains a subcl. (III).

AMENDMENTS

2010—Subsec. (a)(5)(C). Pub. L. 111-148, § 3209(a), added subpar. (C).

Subsec. (a)(6)(A). Pub. L. 111-148, § 3201(d)(1), which directed insertion of “Information to be submitted under this paragraph shall be certified by a qualified member of the American Academy of Actuaries and shall meet actuarial guidelines and rules established by the Secretary under subparagraph (B)(v).” at end of concluding provisions, was repealed by Pub. L. 111-152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (a)(6)(B)(i). Pub. L. 111-148, § 3201(d)(2)(A), which directed substitution of “(iii), (iv), and (v)” for “(iii) and (iv)”, was repealed by Pub. L. 111-152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (a)(6)(B)(v). Pub. L. 111-148, § 3201(d)(2)(B), which directed addition of cl. (v), was repealed by Pub. L. 111-152, § 1102(a). As enacted, text read as follows:

“(I) IN GENERAL.—In order to establish fair MA competitive benchmarks under section 1395w-23(j)(1)(A)(i) of this title, the Secretary, acting through the Chief Actuary of the Centers for Medicare & Medicaid Services (in this clause referred to as the ‘Chief Actuary’), shall establish—

“(aa) actuarial guidelines for the submission of bid information under this paragraph; and

“(bb) bidding rules that are appropriate to ensure accurate bids and fair competition among MA plans.

“(II) DENIAL OF BID AMOUNTS.—The Secretary shall deny monthly bid amounts submitted under subparagraph (A) that do not meet the actuarial guidelines and rules established under subclause (I).

“(III) REFUSAL TO ACCEPT CERTAIN BIDS DUE TO MISREPRESENTATIONS AND FAILURES TO ADEQUATELY MEET REQUIREMENTS.—In the case where the Secretary determines that information submitted by an MA organization under subparagraph (A) contains consistent misrepresentations and failures to adequately meet requirements of the organization, the Secretary may refuse to accept any additional such bid amounts from the organization for the plan year and the Chief Actuary shall, if the Chief Actuary determines that the actuaries of the organization were complicit in those misrepresentations and failures, report those actuaries to the Actuarial Board for Counseling and Discipline.” See Effective Date of 2010 Amendment note below.

Subsec. (b)(1)(C)(i). Pub. L. 111-152, §1102(d)(1), inserted “(or the applicable rebate percentage specified in clause (iii) in the case of plan years beginning on or after January 1, 2012)” after “75 percent”.

Pub. L. 111-148, §3201(c), which directed insertion of “(or 100 percent in the case of plan years beginning on or after January 1, 2014)” after “75 percent”, was repealed by Pub. L. 111-152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (b)(1)(C)(ii). Pub. L. 111-148, §3202(b)(1)(A), substituted “rebate for plan years before 2012” for “rebate” in heading and “For plan years before 2012, a rebate” for “A rebate” in introductory provisions.

Subsec. (b)(1)(C)(iii). Pub. L. 111-152, §1102(d)(2), added cl. (iii) and struck out former cl. (iii). Prior to amendment, text read as follows: “For plan years beginning on or after January 1, 2012, a rebate required under this subparagraph may not be used for the purpose described in clause (ii)(III) and shall be provided through the application of the amount of the rebate in the following priority order:

“(I) First, to use the most significant share to meaningfully reduce cost-sharing otherwise applicable for benefits under the original medicare fee-for-service program under parts A and B and for qualified prescription drug coverage under part D, including the reduction of any deductibles, copayments, and maximum limitations on out-of-pocket expenses otherwise applicable. Any reduction of maximum limitations on out-of-pocket expenses under the preceding sentence shall apply to all benefits under the original medicare fee-for-service program option. The Secretary may provide guidance on meaningfully reducing cost-sharing under this subclause, except that such guidance may not require a particular amount of cost-sharing or reduction in cost-sharing.

“(II) Second, to use the next most significant share to meaningfully provide coverage of preventive and wellness health care benefits (as defined by the Secretary) which are not benefits under the original medicare fee-for-service program, such as smoking cessation, a free flu shot, and an annual physical examination.

“(III) Third, to use the remaining share to meaningfully provide coverage of other health care benefits which are not benefits under the original medicare fee-for-service program, such as eye examinations and dental coverage, and are not benefits described in subclause (II).”

Pub. L. 111-148, §3202(b)(1)(C), added cl. (iii).

Subsec. (b)(1)(C)(iv). Pub. L. 111-152, §1102(d)(2), added cl. (iv). Former cl. (iv) redesignated (vii).

Pub. L. 111-148, §3202(b)(1)(B), redesignated cl. (iii) as (iv).

Subsec. (b)(1)(C)(v). Pub. L. 111-152, §1102(d)(2), added cl. (v). Former cl. (v) redesignated (viii).

Pub. L. 111-148, §3202(b)(1)(B), redesignated cl. (iv) as (v).

Subsec. (b)(1)(C)(vi) to (viii). Pub. L. 111-152, §1102(d)(2), added cl. (vi) and redesignated cls. (iv) and (v) as (vii) and (viii), respectively.

Subsec. (b)(2)(C). Pub. L. 111-148, §3202(b)(3), designated existing text as cl. (i), inserted cl. (i) heading, and added cl. (ii).

Subsec. (b)(3)(B)(i). Pub. L. 111-148, §3201(a)(2)(B)(i), which directed substitution of “1395w-23(j)(1)(A)” for “1395w-23(j)(1)”, was repealed by Pub. L. 111-152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (b)(4)(B)(i). Pub. L. 111-148, §3201(a)(2)(B)(ii), which directed substitution of “1395w-23(j)(1)(B)” for “1395w-23(j)(2)”, was repealed by Pub. L. 111-152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (h). Pub. L. 111-148, §3201(e)(2)(A)(v), which directed repeal of subsec. (h), was repealed by Pub. L. 111-152, §1102(a). See Effective Date of 2010 Amendment note below.

2003—Pub. L. 108-173, §222(g)(1)(A), substituted “Premiums and bid amounts” for “Premiums” in section catchline.

Subsec. (a). Pub. L. 108-173, §222(g)(1)(B), inserted “, bid amounts,” after “premiums” in heading.

Subsec. (a)(1). Pub. L. 108-173, §222(a)(1)(A), reenacted heading without change and amended text generally. Prior to amendment, text read as follows: “Not later than the second Monday in September of 2002, 2003, and 2004 (or July 1 of each other year), each Medicare+Choice organization shall submit to the Secretary, in a form and manner specified by the Secretary and for each Medicare+Choice plan for the service area (or segment of such an area if permitted under subsection (h) of this section) in which it intends to be offered in the following year—

“(A) the information described in paragraph (2), (3), or (4) for the type of plan involved; and

“(B) the enrollment capacity (if any) in relation to the plan and area.”

Subsec. (a)(2). Pub. L. 108-173, §222(g)(1)(C), inserted “before 2006” after “for coordinated care plans” in heading and “for a year before 2006” after “section 1395w-21(a)(2)(A) of this title” in introductory provisions.

Subsec. (a)(3). Pub. L. 108-173, §222(g)(1)(D), substituted “For an MSA plan for any year” for “For an MSA plan described” in introductory provisions.

Subsec. (a)(4). Pub. L. 108-173, §222(g)(1)(E), inserted “before 2006” after “for private fee-for-service plans” in heading and “for a year before 2006” after “section 1395w-22(a)(1)(A) of this title” in introductory provisions.

Subsec. (a)(5)(A). Pub. L. 108-173, §900(e)(1)(H), substituted “Centers for Medicare & Medicaid Services” for “Health Care Financing Administration”.

Pub. L. 108-173, §222(g)(1)(F), inserted “paragraphs (2) and (4) of” after “filed under”.

Subsec. (a)(5)(B). Pub. L. 108-173, §222(g)(1)(G), inserted “, in the case of an MA private fee-for-service plan,” after “paragraph (3) or”.

Subsec. (a)(6). Pub. L. 108-173, §222(a)(1)(B), added par. (6).

Subsec. (b)(1)(A). Pub. L. 108-173, §222(b)(1)(A), (g)(1)(H), substituted “Subject to the rebate under subparagraph (C), the monthly amount (if any)” for “The monthly amount” and a comma for “and” after “basic beneficiary premium” and inserted before period at end “, and, if the plan provides qualified prescription drug coverage, the MA monthly prescription drug beneficiary premium”.

Subsec. (b)(1)(C). Pub. L. 108-173, §222(b)(1)(B), added subpar. (C).

Subsec. (b)(2). Pub. L. 108-173, §222(b)(2), inserted “and bid” after “Premium” in heading, added subpars. (A) to (C) and (E), redesignated former subpar. (C) as (D), and struck out former subpars. (A) and (B) which defined the terms “Medicare+Choice monthly basic beneficiary premium” and “Medicare+Choice monthly supplemental beneficiary premium”.

Subsec. (b)(3), (4). Pub. L. 108-173, §222(b)(3), added pars. (3) and (4).

Subsec. (c). Pub. L. 108-173, §222(g)(2), amended heading and text of subsec. (c) generally. Prior to amendment, text read as follows: “The Medicare+Choice monthly basic and supplemental beneficiary premium,

the Medicare+Choice monthly MSA premium charged under subsection (b) of this section of a Medicare+Choice organization under this part may not vary among individuals enrolled in the plan.”

Subsec. (d). Pub. L. 108-173, § 222(c), (g)(3), designated existing provisions as par. (1), inserted heading and “, prescription drug,” after “basic”, and added pars. (2) to (4).

Subsec. (e)(1). Pub. L. 108-173, § 222(g)(4)(A), inserted “before 2006” after “benefits” in heading and substituted “For periods before 2006, in” for “In” in introductory provisions.

Subsec. (e)(2). Pub. L. 108-173, § 222(g)(4)(B), inserted “before 2006” after “benefits” in heading and substituted “For periods before 2006, if” for “If” in text.

Subsec. (e)(3). Pub. L. 108-173, § 222(g)(4)(C), substituted “, (2), or (4)” for “or (2)”.

Subsec. (e)(4). Pub. L. 108-173, § 222(g)(4)(D)(i), (ii), inserted “and for basic benefits beginning in 2006” after “plans” in heading and “and for periods beginning with 2006, with respect to an MA plan described in section 1395w-21(a)(2)(A) of this title” after “MSA plan” in introductory provisions.

Subsec. (e)(4)(A). Pub. L. 108-173, § 222(g)(4)(D)(iii), substituted “benefits under the original medicare fee-for-service program option” for “required benefits described in section 1395w-22(a)(1) of this title”.

Subsec. (e)(4)(B). Pub. L. 108-173, § 222(g)(4)(D)(iv), inserted “with respect to such benefits” after “would be applicable”.

Subsec. (f). Pub. L. 108-173, § 222(g)(5)(A), inserted “before 2006” after “additional benefits” in heading.

Subsec. (f)(1)(A). Pub. L. 108-173, § 222(g)(5)(B), substituted “For years before 2006, each” for “Each”.

Subsec. (g). Pub. L. 108-173, § 232(b), inserted “or premiums paid to such organizations under this part” after “section 1395w-23 of this title”.

2002—Subsec. (a)(1). Pub. L. 107-188 substituted “Not later than the second Monday in September of 2002, 2003, and 2004 (or July 1 of each other year)” for “Not later than July 1 of each year” in introductory provisions.

2000—Subsec. (a)(5)(A). Pub. L. 106-554, § 1(a)(6) [title VI, § 622(a)], substituted “values so submitted” for “value so submitted” and inserted at end “The Chief Actuary of the Health Care Financing Administration shall review the actuarial assumptions and data used by the Medicare+Choice organization with respect to such rates, amounts, and values so submitted to determine the appropriateness of such assumptions and data.”

Subsec. (f)(1)(E), (F). Pub. L. 106-554, § 1(a)(6) [title VI, § 606(a)(1)], added subpar. (E) and redesignated former subpar. (E) as (F).

1999—Subsec. (a)(1). Pub. L. 106-113, § 1000(a)(6) [title V, § 516(a)], substituted “July 1” for “May 1” in introductory provisions.

Pub. L. 106-113, § 1000(a)(6) [title V, § 515(a)(1)], inserted “(or segment of such an area if permitted under subsection (h) of this section)” after “service area” in introductory provisions.

Subsec. (a)(2)(A). Pub. L. 106-113, § 1000(a)(6) [title III, § 321(k)(6)(C)(i)(I)], inserted “section” before “1395w-22(a)(1)(A) of this title” in introductory provisions.

Subsec. (a)(2)(B). Pub. L. 106-113, § 1000(a)(6) [title III, § 321(k)(6)(C)(i)(II)], inserted “section” after “described in” in introductory provisions.

Subsec. (a)(3)(A), (B). Pub. L. 106-113, § 1000(a)(6) [title III, § 321(k)(6)(C)(ii)], inserted “section” after “described in”.

Subsec. (a)(4). Pub. L. 106-113, § 1000(a)(6) [title III, § 321(k)(6)(C)(iii)(I)], which directed insertion of “section” after “described in”, was executed by making the insertion after “described in” the second time appearing in introductory provisions to reflect the probable intent of Congress.

Subsec. (a)(4)(A). Pub. L. 106-113, § 1000(a)(6) [title III, § 321(k)(6)(C)(iii)(II)], inserted “section” after “described in” in introductory provisions.

Subsec. (a)(4)(B). Pub. L. 106-113, § 1000(a)(6) [title III, § 321(k)(6)(C)(iii)(III)], inserted “section” after “described in”.

Subsec. (h). Pub. L. 106-113, § 1000(a)(6) [title V, § 515(a)(2)], added subsec. (h).

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108-173, set out as a note under section 1395w-21 of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Repeal of sections 3201 and 3203 of Pub. L. 111-148 and the amendments made by such sections, effective as if included in the enactment of Pub. L. 111-148, see section 1102(a) of Pub. L. 111-152, set out as a note under section 1395w-21 of this title.

Pub. L. 111-148, title III, § 3201(d)(3), Mar. 23, 2010, 124 Stat. 445, which provided that amendments by section 3201(d) of Pub. L. 111-148 (amending this section) would apply to bid amounts submitted on or after Jan. 1, 2012, was repealed by Pub. L. 111-152, title I, § 1102(a), Mar. 30, 2010, 124 Stat. 1040.

Pub. L. 111-148, title III, § 3209(c), Mar. 23, 2010, 124 Stat. 460, provided that: “The amendments made by this section [amending this section and section 1395w-111 of this title] shall apply to bids submitted for contract years beginning on or after January 1, 2011.”

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by section 222(a)(1), (b), (c), (g) of Pub. L. 108-173 applicable with respect to plan years beginning on or after Jan. 1, 2006, see section 223(a) of Pub. L. 108-173, set out as a note under section 1395w-21 of this title.

Pub. L. 108-173, title II, § 232(c), Dec. 8, 2003, 117 Stat. 2209, provided that: “The amendments made by this subsection [probably should be “this section”, amending this section and section 1395w-26 of this title] shall take effect on the date of the enactment of this Act [Dec. 8, 2003].”

EFFECTIVE DATE OF 2002 AMENDMENT

Pub. L. 107-188, title V, § 532(b)(2), June 12, 2002, 116 Stat. 696, provided that: “The amendment made by paragraph (1) [amending this section] shall apply to information submitted for years beginning with 2003.”

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by section 1(a)(6) [title VI, § 606(a)(1)] of Pub. L. 106-554 applicable to years beginning with 2003, see section 1(a)(6) [title VI, § 606(b)] of Pub. L. 106-554, set out as a note under section 1395r of this title.

Pub. L. 106-554, § 1(a)(6) [title VI, § 622(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-566, provided that: “The amendments made by subsection (a) [amending this section] shall apply to submissions made on or after May 1, 2001.”

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 1000(a)(6) [title III, § 321(k)(6)(C)] of Pub. L. 106-113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105-33, except as otherwise provided, see section 1000(a)(6) [title III, § 321(m)] of Pub. L. 106-113, set out as a note under section 1395d of this title.

Pub. L. 106-113, div. B, § 1000(a)(6) [title V, § 515(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A-384, provided that: “The amendments made by this section [amending this section] apply to contract years beginning on or after January 1, 2001.”

Pub. L. 106-113, div. B, § 1000(a)(6) [title V, § 516(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A-384, provided that: “The amendment made by subsection (a) [amending this section] applies to information submitted by

Medicare+Choice organizations for years beginning with 1999.”

§ 1395w-25. Organizational and financial requirements for Medicare+Choice organizations; provider-sponsored organizations

(a) Organized and licensed under State law

(1) In general

Subject to paragraphs (2) and (3), a Medicare+Choice organization shall be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a Medicare+Choice plan.

(2) Special exception for provider-sponsored organizations

(A) In general

In the case of a provider-sponsored organization that seeks to offer a Medicare+Choice plan in a State, the Secretary shall waive the requirement of paragraph (1) that the organization be licensed in that State if—

- (i) the organization files an application for such waiver with the Secretary by not later than November 1, 2002, and
- (ii) the Secretary determines, based on the application and other evidence presented to the Secretary, that any of the grounds for approval of the application described in subparagraph (B), (C), or (D) has been met.

(B) Failure to act on licensure application on a timely basis

The ground for approval of such a waiver application described in this subparagraph is that the State has failed to complete action on a licensing application of the organization within 90 days of the date of the State's receipt of a substantially complete application. No period before August 5, 1997, shall be included in determining such 90-day period.

(C) Denial of application based on discriminatory treatment

The ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application and—

- (i) the standards or review process imposed by the State as a condition of approval of the license imposes any material requirements, procedures, or standards (other than solvency requirements) to such organizations that are not generally applicable to other entities engaged in a substantially similar business, or
- (ii) the State requires the organization, as a condition of licensure, to offer any product or plan other than a Medicare+Choice plan.

(D) Denial of application based on application of solvency requirements

With respect to waiver applications filed on or after the date of publication of solvency standards under section 1395w-26(a) of this title, the ground for approval of such a waiver application described in this subparagraph is that the State has denied such a li-

censing application based (in whole or in part) on the organization's failure to meet applicable solvency requirements and—

- (i) such requirements are not the same as the solvency standards established under section 1395w-26(a) of this title; or
- (ii) the State has imposed as a condition of approval of the license documentation or information requirements relating to solvency or other material requirements, procedures, or standards relating to solvency that are different from the requirements, procedures, and standards applied by the Secretary under subsection (d)(2) of this section.

For purposes of this paragraph, the term “solvency requirements” means requirements relating to solvency and other matters covered under the standards established under section 1395w-26(a) of this title.

(E) Treatment of waiver

In the case of a waiver granted under this paragraph for a provider-sponsored organization with respect to a State—

(i) Limitation to State

The waiver shall be effective only with respect to that State and does not apply to any other State.

(ii) Limitation to 36-month period

The waiver shall be effective only for a 36-month period and may not be renewed.

(iii) Conditioned on compliance with consumer protection and quality standards

The continuation of the waiver is conditioned upon the organization's compliance with the requirements described in subparagraph (G).

(iv) Preemption of State law

Any provisions of law of that State which relate to the licensing of the organization and which prohibit the organization from providing coverage pursuant to a contract under this part shall be superseded.

(F) Prompt action on application

The Secretary shall grant or deny such a waiver application within 60 days after the date the Secretary determines that a substantially complete waiver application has been filed. Nothing in this section shall be construed as preventing an organization which has had such a waiver application denied from submitting a subsequent waiver application.

(G) Application and enforcement of State consumer protection and quality standards

(i) In general

A waiver granted under this paragraph to an organization with respect to licensing under State law is conditioned upon the organization's compliance with all consumer protection and quality standards insofar as such standards—

- (I) would apply in the State to the organization if it were licensed under State law;

(II) are generally applicable to other Medicare+Choice organizations and plans in the State; and

(III) are consistent with the standards established under this part.

Such standards shall not include any standard preempted under section 1395w-26(b)(3)(B) of this title.

(ii) Incorporation into contract

In the case of such a waiver granted to an organization with respect to a State, the Secretary shall incorporate the requirement that the organization (and Medicare+Choice plans it offers) comply with standards under clause (i) as part of the contract between the Secretary and the organization under section 1395w-27 of this title.

(iii) Enforcement

In the case of such a waiver granted to an organization with respect to a State, the Secretary may enter into an agreement with the State under which the State agrees to provide for monitoring and enforcement activities with respect to compliance of such an organization and its Medicare+Choice plans with such standards. Such monitoring and enforcement shall be conducted by the State in the same manner as the State enforces such standards with respect to other Medicare+Choice organizations and plans, without discrimination based on the type of organization to which the standards apply. Such an agreement shall specify or establish mechanisms by which compliance activities are undertaken, while not lengthening the time required to review and process applications for waivers under this paragraph.

(H) Report

By not later than December 31, 2001, the Secretary shall submit to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate a report regarding whether the waiver process under this paragraph should be continued after December 31, 2002. In making such recommendation, the Secretary shall consider, among other factors, the impact of such process on beneficiaries and on the long-term solvency of the program under this subchapter.

(3) Licensure does not substitute for or constitute certification

The fact that an organization is licensed in accordance with paragraph (1) does not deem the organization to meet other requirements imposed under this part.

(b) Assumption of full financial risk

The Medicare+Choice organization shall assume full financial risk on a prospective basis for the provision of the health care services for which benefits are required to be provided under section 1395w-22(a)(1) of this title, except that the organization—

(1) may obtain insurance or make other arrangements for the cost of providing to any enrolled member such services the aggregate value of which exceeds such aggregate level as the Secretary specifies from time to time,

(2) may obtain insurance or make other arrangements for the cost of such services provided to its enrolled members other than through the organization because medical necessity required their provision before they could be secured through the organization,

(3) may obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year, and

(4) may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions.

(c) Certification of provision against risk of insolvency for unlicensed PSOs

(1) In general

Each Medicare+Choice organization that is a provider-sponsored organization, that is not licensed by a State under subsection (a) of this section, and for which a waiver application has been approved under subsection (a)(2) of this section, shall meet standards established under section 1395w-26(a) of this title relating to the financial solvency and capital adequacy of the organization.

(2) Certification process for solvency standards for PSOs

The Secretary shall establish a process for the receipt and approval of applications of a provider-sponsored organization described in paragraph (1) for certification (and periodic recertification) of the organization as meeting such solvency standards. Under such process, the Secretary shall act upon such a certification application not later than 60 days after the date the application has been received.

(d) “Provider-sponsored organization” defined

(1) In general

In this part, the term “provider-sponsored organization” means a public or private entity—

(A) that is established or organized, and operated, by a health care provider, or group of affiliated health care providers,

(B) that provides a substantial proportion (as defined by the Secretary in accordance with paragraph (2)) of the health care items and services under the contract under this part directly through the provider or affiliated group of providers, and

(C) with respect to which the affiliated providers share, directly or indirectly, substantial financial risk with respect to the provision of such items and services and have at least a majority financial interest in the entity.

(2) Substantial proportion

In defining what is a “substantial proportion” for purposes of paragraph (1)(B), the Secretary—

(A) shall take into account the need for such an organization to assume responsibility for providing—

(i) significantly more than the majority of the items and services under the contract under this section through its own affiliated providers; and

(ii) most of the remainder of the items and services under the contract through providers with which the organization has an agreement to provide such items and services,

in order to assure financial stability and to address the practical considerations involved in integrating the delivery of a wide range of service providers;

(B) shall take into account the need for such an organization to provide a limited proportion of the items and services under the contract through providers that are neither affiliated with nor have an agreement with the organization; and

(C) may allow for variation in the definition of substantial proportion among such organizations based on relevant differences among the organizations, such as their location in an urban or rural area.

(3) Affiliation

For purposes of this subsection, a provider is “affiliated” with another provider if, through contract, ownership, or otherwise—

(A) one provider, directly or indirectly, controls, is controlled by, or is under common control with the other,

(B) both providers are part of a controlled group of corporations under section 1563 of the Internal Revenue Code of 1986,

(C) each provider is a participant in a lawful combination under which each provider shares substantial financial risk in connection with the organization’s operations, or

(D) both providers are part of an affiliated service group under section 414 of such Code.

(4) Control

For purposes of paragraph (3), control is presumed to exist if one party, directly or indirectly, owns, controls, or holds the power to vote, or proxies for, not less than 51 percent of the voting rights or governance rights of another.

(5) “Health care provider” defined

In this subsection, the term “health care provider” means—

(A) any individual who is engaged in the delivery of health care services in a State and who is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, and

(B) any entity that is engaged in the delivery of health care services in a State and that, if it is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, is so licensed.

(6) Regulations

The Secretary shall issue regulations to carry out this subsection.

(Aug. 14, 1935, ch. 531, title XVIII, § 1855, as added Pub. L. 105-33, title IV, § 4001, Aug. 5, 1997, 111 Stat. 312.)

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (d)(3)(B), (D), is classified generally to Title 26, Internal Revenue Code.

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108-173, set out as a note under section 1395w-21 of this title.

Committee on Commerce of House of Representatives changed to Committee on Energy and Commerce of House of Representatives, and jurisdiction over matters relating to securities and exchanges and insurance generally transferred to Committee on Financial Services of House of Representatives by House Resolution No. 5, One Hundred Seventh Congress, Jan. 3, 2001.

§ 1395w-26. Establishment of standards**(a) Establishment of solvency standards for provider-sponsored organizations****(1) Establishment****(A) In general**

The Secretary shall establish, on an expedited basis and using a negotiated rule-making process under subchapter III of chapter 5 of title 5, standards described in section 1395w-25(c)(1) of this title (relating to the financial solvency and capital adequacy of the organization) that entities must meet to qualify as provider-sponsored organizations under this part.

(B) Factors to consider for solvency standards

In establishing solvency standards under subparagraph (A) for provider-sponsored organizations, the Secretary shall consult with interested parties and shall take into account—

(i) the delivery system assets of such an organization and ability of such an organization to provide services directly to enrollees through affiliated providers,

(ii) alternative means of protecting against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, partnerships with other licensed entities, and valuation attributable to the ability of such an organization to meet its service obligations through direct delivery of care, and

(iii) any standards developed by the National Association of Insurance Commissioners specifically for risk-based health care delivery organizations.

(C) Enrollee protection against insolvency

Such standards shall include provisions to prevent enrollees from being held liable to any person or entity for the Medicare+

Choice organization's debts in the event of the organization's insolvency.

(2) Publication of notice

In carrying out the rulemaking process under this subsection, the Secretary, after consultation with the National Association of Insurance Commissioners, the American Academy of Actuaries, organizations representative of medicare beneficiaries, and other interested parties, shall publish the notice provided for under section 564(a) of title 5 by not later than 45 days after August 5, 1997.

(3) Target date for publication of rule

As part of the notice under paragraph (2), and for purposes of this subsection, the "target date for publication" (referred to in section 564(a)(5) of such title) shall be April 1, 1998.

(4) Abbreviated period for submission of comments

In applying section 564(c) of such title under this subsection, "15 days" shall be substituted for "30 days".

(5) Appointment of negotiated rulemaking committee and facilitator

The Secretary shall provide for—

(A) the appointment of a negotiated rulemaking committee under section 565(a) of such title by not later than 30 days after the end of the comment period provided for under section 564(c) of such title (as shortened under paragraph (4)), and

(B) the nomination of a facilitator under section 566(c) of such title by not later than 10 days after the date of appointment of the committee.

(6) Preliminary committee report

The negotiated rulemaking committee appointed under paragraph (5) shall report to the Secretary, by not later than January 1, 1998, regarding the committee's progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before 1 month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress towards such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this subsection through such other methods as the Secretary may provide.

(7) Final committee report

If the committee is not terminated under paragraph (6), the rulemaking committee shall submit a report containing a proposed rule by not later than 1 month before the target date of publication.

(8) Interim, final effect

The Secretary shall publish a rule under this subsection in the Federal Register by not later than the target date of publication. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for

a period (of not less than 60 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications of entities to be certified as provider-sponsored organizations pursuant to such rules and consistent with this subsection.

(9) Publication of rule after public comment

The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target date of publication.

(b) Establishment of other standards

(1) In general

The Secretary shall establish by regulation other standards (not described in subsection (a) of this section) for Medicare+Choice organizations and plans consistent with, and to carry out, this part. The Secretary shall publish such regulations by June 1, 1998. In order to carry out this requirement in a timely manner, the Secretary may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

(2) Use of current standards

Consistent with the requirements of this part, standards established under this subsection shall be based on standards established under section 1395mm of this title to carry out analogous provisions of such section.

(3) Relation to State laws

The standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to MA plans which are offered by MA organizations under this part.

(4) Prohibition of midyear implementation of significant new regulatory requirements

The Secretary may not implement, other than at the beginning of a calendar year, regulations under this section that impose new, significant regulatory requirements on a Medicare+Choice organization or plan.

(Aug. 14, 1935, ch. 531, title XVIII, §1856, as added Pub. L. 105-33, title IV, §4001, Aug. 5, 1997, 111 Stat. 317; amended Pub. L. 106-554, §1(a)(6) [title VI, §§612(a), 614(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A-560; Pub. L. 108-173, title II, §232(a), Dec. 8, 2003, 117 Stat. 2208.)

AMENDMENTS

2003—Subsec. (b)(3). Pub. L. 108-173 reenacted heading without change and amended text generally. Prior to amendment, text consisted of subpars. (A) and (B) stating general rule and listing standards specifically superseded.

2000—Subsec. (b)(3)(B)(i). Pub. L. 106-554, §1(a)(6) [title VI, §614(a)(1)], inserted "(including cost-sharing requirements)" after "Benefit requirements".

Subsec. (b)(3)(B)(iv). Pub. L. 106-554, §1(a)(6) [title VI, §614(a)(2)], added cl. (iv).

Subsec. (b)(4). Pub. L. 106-554, §1(a)(6) [title VI, §612(a)], added par. (4).

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate

transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108-173, set out as a note under section 1395w-21 of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106-554, §1(a)(6) [title VI, §612(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-560, provided that: “The amendment made by subsection (a) [amending this section] takes effect on the date of the enactment of this Act [Dec. 21, 2000].”

Pub. L. 106-554, §1(a)(6) [title VI, §614(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-561, provided that: “The amendments made by subsection (a) [amending this section] take effect on the date of the enactment of this Act [Dec. 21, 2000].”

§ 1395w-27. Contracts with Medicare+Choice organizations

(a) In general

The Secretary shall not permit the election under section 1395w-21 of this title of a Medicare+Choice plan offered by a Medicare+Choice organization under this part, and no payment shall be made under section 1395w-23 of this title to an organization, unless the Secretary has entered into a contract under this section with the organization with respect to the offering of such plan. Such a contract with an organization may cover more than 1 Medicare+Choice plan. Such contract shall provide that the organization agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

(b) Minimum enrollment requirements

(1) In general

Subject to paragraph (2), the Secretary may not enter into a contract under this section with a Medicare+Choice organization unless the organization has—

(A) at least 5,000 individuals (or 1,500 individuals in the case of an organization that is a provider-sponsored organization) who are receiving health benefits through the organization, or

(B) at least 1,500 individuals (or 500 individuals in the case of an organization that is a provider-sponsored organization) who are receiving health benefits through the organization if the organization primarily serves individuals residing outside of urbanized areas.

(2) Application to MSA plans

In applying paragraph (1) in the case of a Medicare+Choice organization that is offering an MSA plan, paragraph (1) shall be applied by substituting covered lives for individuals.

(3) Allowing transition

The Secretary may waive the requirement of paragraph (1) during the first 3 contract years with respect to an organization.

(c) Contract period and effectiveness

(1) Period

Each contract under this section shall be for a term of at least 1 year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term.

(2) Termination authority

In accordance with procedures established under subsection (h) of this section, the Secretary may at any time terminate any such contract if the Secretary determines that the organization—

(A) has failed substantially to carry out the contract;

(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part; or

(C) no longer substantially meets the applicable conditions of this part.

(3) Effective date of contracts

The effective date of any contract executed pursuant to this section shall be specified in the contract, except that in no case shall a contract under this section which provides for coverage under an MSA plan be effective before January 1999 with respect to such coverage.

(4) Previous terminations

(A) In general

The Secretary may not enter into a contract with a Medicare+Choice organization if a previous contract with that organization under this section was terminated at the request of the organization within the preceding 2-year period, except as provided in subparagraph (B) and except in such other circumstances which warrant special consideration, as determined by the Secretary.

(B) Earlier re-entry permitted where change in payment policy

Subparagraph (A) shall not apply with respect to the offering by a Medicare+Choice organization of a Medicare+Choice plan in a Medicare+Choice payment area if during the 6-month period beginning on the date the organization notified the Secretary of the intention to terminate the most recent previous contract, there was a legislative change enacted (or a regulatory change adopted) that has the effect of increasing payment amounts under section 1395w-23 of this title for that Medicare+Choice payment area.

(5) Contracting authority

The authority vested in the Secretary by this part may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this subchapter.

(d) Protections against fraud and beneficiary protections

(1) Periodic auditing

The Secretary shall provide for the annual auditing of the financial records (including data relating to medicare utilization and costs, including allowable costs under section 1395w-27a(c) of this title) of at least one-third of the Medicare+Choice organizations offering Medicare+Choice plans under this part. The Comptroller General shall monitor auditing activities conducted under this subsection.

(2) Inspection and audit

Each contract under this section shall provide that the Secretary, or any person or organization designated by the Secretary—

(A) shall have the right to timely inspect or otherwise evaluate (i) the quality, appropriateness, and timeliness of services performed under the contract, and (ii) the facilities of the organization when there is reasonable evidence of some need for such inspection, and

(B) shall have the right to timely audit and inspect any books and records of the Medicare+Choice organization that pertain (i) to the ability of the organization to bear the risk of potential financial losses, or (ii) to services performed or determinations of amounts payable under the contract.

(3) Enrollee notice at time of termination

Each contract under this section shall require the organization to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this subchapter, to each individual enrolled with the organization under this part.

(4) Disclosure**(A) In general**

Each Medicare+Choice organization shall, in accordance with regulations of the Secretary, report to the Secretary financial information which shall include the following:

(i) Such information as the Secretary may require demonstrating that the organization has a fiscally sound operation.

(ii) A copy of the report, if any, filed with the Secretary containing the information required to be reported under section 1320a-3 of this title by disclosing entities.

(iii) A description of transactions, as specified by the Secretary, between the organization and a party in interest. Such transactions shall include—

(I) any sale or exchange, or leasing of any property between the organization and a party in interest;

(II) any furnishing for consideration of goods, services (including management services), or facilities between the organization and a party in interest, but not including salaries paid to employees for services provided in the normal course of their employment and health services provided to members by hospitals and other providers and by staff, medical group (or groups), individual practice association (or associations), or any combination thereof; and

(III) any lending of money or other extension of credit between an organization and a party in interest.

The Secretary may require that information reported respecting an organization which controls, is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

(B) "Party in interest" defined

For the purposes of this paragraph, the term "party in interest" means—

(i) any director, officer, partner, or employee responsible for management or administration of a Medicare+Choice organization, any person who is directly or indirectly the beneficial owner of more than 5 percent of the equity of the organization, any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5 percent of the organization, and, in the case of a Medicare+Choice organization organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

(ii) any entity in which a person described in clause (i)—

(I) is an officer or director;

(II) is a partner (if such entity is organized as a partnership);

(III) has directly or indirectly a beneficial interest of more than 5 percent of the equity; or

(IV) has a mortgage, deed of trust, note, or other interest valuing more than 5 percent of the assets of such entity;

(iii) any person directly or indirectly controlling, controlled by, or under common control with an organization; and

(iv) any spouse, child, or parent of an individual described in clause (i).

(C) Access to information

Each Medicare+Choice organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.

(5) Loan information

The contract shall require the organization to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties.

(6) Review to ensure compliance with care management requirements for specialized Medicare Advantage plans for special needs individuals

In conjunction with the periodic audit of a specialized Medicare Advantage plan for special needs individuals under paragraph (1), the Secretary shall conduct a review to ensure that such organization offering the plan meets the requirements described in section 1395w-28(f)(5) of this title.

(e) Additional contract terms**(1) In general**

The contract shall contain such other terms and conditions not inconsistent with this part (including requiring the organization to provide the Secretary with such information) as the Secretary may find necessary and appropriate.

(2) Cost-sharing in enrollment-related costs**(A) In general**

A Medicare+Choice organization and a PDP sponsor under part D of this subchapter

shall pay the fee established by the Secretary under subparagraph (B).

(B) Authorization

The Secretary is authorized to charge a fee to each Medicare+Choice organization with a contract under this part and each PDP sponsor with a contract under part D of this subchapter that is equal to the organization's or sponsor's pro rata share (as determined by the Secretary) of the aggregate amount of fees which the Secretary is directed to collect in a fiscal year. Any amounts collected shall be available without further appropriation to the Secretary for the purpose of carrying out section 1395w-21 of this title (relating to enrollment and dissemination of information), section 1395w-101(c) of this title, and section 1395b-4 of this title (relating to the health insurance counseling and assistance program).

(C) Authorization of appropriations

There are authorized to be appropriated for the purposes described in subparagraph (B) for each fiscal year beginning with fiscal year 2001 and ending with fiscal year 2005 an amount equal to \$100,000,000, and for each fiscal year beginning with fiscal year 2006 an amount equal to \$200,000,000, reduced by the amount of fees authorized to be collected under this paragraph and section 1395w-112(b)(3)(D) of this title for the fiscal year.

(D) Limitation

In any fiscal year the fees collected by the Secretary under subparagraph (B) shall not exceed the lesser of—

- (i) the estimated costs to be incurred by the Secretary in the fiscal year in carrying out the activities described in section 1395w-21 of this title and section 1395w-101(c) of this title and section 1395b-4 of this title; or
- (ii)(I) \$200,000,000 in fiscal year 1998;
- (II) \$150,000,000 in fiscal year 1999;
- (III) \$100,000,000 in fiscal year 2000;
- (IV) the Medicare+Choice portion (as defined in subparagraph (E)) of \$100,000,000 in fiscal year 2001 and each succeeding fiscal year before fiscal year 2006; and
- (V) the applicable portion (as defined in subparagraph (F)) of \$200,000,000 in fiscal year 2006 and each succeeding fiscal year.

(E) Medicare+Choice portion defined

In this paragraph, the term “Medicare+Choice portion” means, for a fiscal year, the ratio, as estimated by the Secretary, of—

- (i) the average number of individuals enrolled in Medicare+Choice plans during the fiscal year, to
- (ii) the average number of individuals entitled to benefits under part A of this subchapter, and enrolled under part B of this subchapter, during the fiscal year.

(F) Applicable portion defined

In this paragraph, the term “applicable portion” means, for a fiscal year—

- (i) with respect to MA organizations, the Secretary's estimate of the total propor-

tion of expenditures under this subchapter that are attributable to expenditures made under this part (including payments under part D of this subchapter that are made to such organizations); or

- (ii) with respect to PDP sponsors, the Secretary's estimate of the total proportion of expenditures under this subchapter that are attributable to expenditures made to such sponsors under part D of this subchapter.

(3) Agreements with federally qualified health centers

(A) Payment levels and amounts

A contract under this section with an MA organization shall require the organization to provide, in any written agreement described in section 1395w-23(a)(4) of this title between the organization and a federally qualified health center, for a level and amount of payment to the federally qualified health center for services provided by such health center that is not less than the level and amount of payment that the plan would make for such services if the services had been furnished by a entity providing similar services that was not a federally qualified health center.

(B) Cost-sharing

Under the written agreement referred to in subparagraph (A), a federally qualified health center must accept the payment amount referred to in such subparagraph plus the Federal payment provided for in section 1395l(a)(3)(B) of this title as payment in full for services covered by the agreement, except that such a health center may collect any amount of cost-sharing permitted under the contract under this section, so long as the amounts of any deductible, coinsurance, or copayment comply with the requirements under section 1395w-24(e) of this title.

(4) Requirement for minimum medical loss ratio

If the Secretary determines for a contract year (beginning with 2014) that an MA plan has failed to have a medical loss ratio of at least .85—

- (A) the MA plan shall remit to the Secretary an amount equal to the product of—

- (i) the total revenue of the MA plan under this part for the contract year; and
- (ii) the difference between .85 and the medical loss ratio;

- (B) for 3 consecutive contract years, the Secretary shall not permit the enrollment of new enrollees under the plan for coverage during the second succeeding contract year; and

- (C) the Secretary shall terminate the plan contract if the plan fails to have such a medical loss ratio for 5 consecutive contract years.

(f) Prompt payment by Medicare+Choice organization

(1) Requirement

A contract under this part shall require a Medicare+Choice organization to provide

prompt payment (consistent with the provisions of sections 1395h(c)(2) and 1395u(c)(2) of this title) of claims submitted for services and supplies furnished to enrollees pursuant to the contract, if the services or supplies are not furnished under a contract between the organization and the provider or supplier (or in the case of a Medicare+Choice private fee-for-service plan, if a claim is submitted to such organization by an enrollee).

(2) Secretary's option to bypass noncomplying organization

In the case of a Medicare+Choice eligible organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with paragraph (1), the Secretary may provide for direct payment of the amounts owed to providers and suppliers (or, in the case of a Medicare+Choice private fee-for-service plan, amounts owed to the enrollees) for covered services and supplies furnished to individuals enrolled under this part under the contract. If the Secretary provides for the direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the organization under this part to reflect the amount of the Secretary's payments (and the Secretary's costs in making the payments).

(3) Incorporation of certain prescription drug plan contract requirements

The following provisions shall apply to contracts with a Medicare Advantage organization offering an MA-PD plan in the same manner as they apply to contracts with a PDP sponsor offering a prescription drug plan under part D:

(A) Prompt payment

Section 1395w-112(b)(4) of this title.

(B) Submission of claims by pharmacies located in or contracting with long-term care facilities

Section 1395w-112(b)(5) of this title.

(C) Regular update of prescription drug pricing standard

Section 1395w-112(b)(6) of this title.

(g) Intermediate sanctions

(1) In general

If the Secretary determines that a Medicare+Choice organization with a contract under this section—

(A) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

(B) imposes premiums on individuals enrolled under this part in excess of the amount of the Medicare+Choice monthly basic and supplemental beneficiary premiums permitted under section 1395w-24 of this title;

(C) acts to expel or to refuse to re-enroll an individual in violation of the provisions of this part;

(D) engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this part) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

(E) misrepresents or falsifies information that is furnished—

(i) to the Secretary under this part, or

(ii) to an individual or to any other entity under this part;

(F) fails to comply with the applicable requirements of section 1395w-22(j)(3) or 1395w-22(k)(2)(A)(ii) of this title;

(G) employs or contracts with any individual or entity that is excluded from participation under this subchapter under section 1320a-7 or 1320a-7a of this title for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services;

(H) except as provided under subparagraph (C) or (D) of section 1395w-101(b)(1) of this title, enrolls an individual in any plan under this part without the prior consent of the individual or the designee of the individual;

(I) transfers an individual enrolled under this part from one plan to another without the prior consent of the individual or the designee of the individual or solely for the purpose of earning a commission;

(J) fails to comply with marketing restrictions described in subsections (h) and (j) of section 1395w-21 of this title or applicable implementing regulations or guidance; or

(K) employs or contracts with any individual or entity who engages in the conduct described in subparagraphs (A) through (J) of this paragraph;

the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2). The Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2), if the Secretary determines that any employee or agent of such organization, or any provider or supplier who contracts with such organization, has engaged in any conduct described in subparagraphs (A) through (K) of this paragraph.

(2) Remedies

The remedies described in this paragraph are—

(A) civil money penalties of not more than \$25,000 for each determination under paragraph (1) or, with respect to a determination under subparagraph (D) or (E)(i) of such paragraph, of not more than \$100,000 for each such determination, except with respect to a determination under subparagraph (E),¹ an assessment of not more than the amount claimed by such plan or plan sponsor based upon the misrepresentation or falsified in-

¹ So in original. Probably means subpar. (E) of par. (1).

formation involved, plus, with respect to a determination under paragraph (1)(B), double the excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under paragraph (1)(D), \$15,000 for each individual not enrolled as a result of the practice involved.

(B) suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

(C) suspension of payment to the organization under this part for individuals enrolled after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

(3) Other intermediate sanctions

In the case of a Medicare+Choice organization for which the Secretary makes a determination under subsection (c)(2) of this section the basis of which is not described in paragraph (1), the Secretary may apply the following intermediate sanctions:

(A) Civil money penalties of not more than \$25,000 for each determination under subsection (c)(2) of this section if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

(B) Civil money penalties of not more than \$10,000 for each week beginning after the initiation of civil money penalty procedures by the Secretary during which the deficiency that is the basis of a determination under subsection (c)(2) of this section exists.

(C) Suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under subsection (c)(2) of this section and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.

(D) Civil monetary penalties of not more than \$100,000, or such higher amount as the Secretary may establish by regulation, where the finding under subsection (c)(2)(A) of this section is based on the organization's termination of its contract under this section other than at a time and in a manner provided for under subsection (a) of this section.

(4) Civil money penalties

The provisions of section 1320a-7a (other than subsections (a) and (b)) of this title shall apply to a civil money penalty under paragraph (2) or (3) in the same manner as they apply to a civil money penalty or proceeding under section 1320a-7a(a) of this title.

(h) Procedures for termination

(1) In general

The Secretary may terminate a contract with a Medicare+Choice organization under this section in accordance with formal investigation and compliance procedures established by the Secretary under which—

(A) the Secretary provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under subsection (c)(2) of this section; and

(B) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before terminating the contract.

(2) Exception for imminent and serious risk to health

Paragraph (1) shall not apply if the Secretary determines that a delay in termination, resulting from compliance with the procedures specified in such paragraph prior to termination, would pose an imminent and serious risk to the health of individuals enrolled under this part with the organization.

(i) Medicare+Choice program compatibility with employer or union group health plans

(1) Contracts with MA organizations

To facilitate the offering of Medicare+Choice plans under contracts between Medicare+Choice organizations and employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations (or combination thereof) to furnish benefits to the entity's employees, former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations, the Secretary may waive or modify requirements that hinder the design of, the offering of, or the enrollment in such Medicare+Choice plans.

(2) Employer sponsored MA plans

To facilitate the offering of MA plans by employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations (or combination thereof) to furnish benefits to the entity's employees, former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations, the Secretary may waive or modify requirements that hinder the design of, the offering of, or the enrollment in such MA plans. Notwithstanding section 1395w-21(g) of this title, an MA plan described in the previous sentence may restrict the enrollment of individuals under this part to individuals who are beneficiaries and participants in such plan.

(Aug. 14, 1935, ch. 531, title XVIII, § 1857, as added Pub. L. 105-33, title IV, § 4001, Aug. 5, 1997, 111 Stat. 319; amended Pub. L. 106-113, div. B, § 1000(a)(6) [title V, §§ 513(a), (b)(1), 522(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A-383, 1501A-387; Pub. L. 106-554, § 1(a)(6) [title VI, §§ 617(a), 623(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A-561, 2763A-566; Pub. L. 108-173, title II, §§ 222(j), (k), (l)(3)(C), 237(c),

title IX, §900(e)(1)(I), Dec. 8, 2003, 117 Stat. 2205, 2207, 2213, 2372; Pub. L. 110-275, title I, §§164(d)(2), 171(b), 172(a)(2), 173(b), July 15, 2008, 122 Stat. 2574, 2580, 2581; Pub. L. 111-148, title VI, §6408(b), Mar. 23, 2010, 124 Stat. 771; Pub. L. 111-152, title I, §1103, Mar. 30, 2010, 124 Stat. 1047.)

AMENDMENTS

2010—Subsec. (d)(2)(A). Pub. L. 111-148, §6408(b)(1)(A), inserted “timely” before “inspect”.

Subsec. (d)(2)(B). Pub. L. 111-148, §6408(b)(1)(B), inserted “timely” before “audit and inspect”.

Subsec. (e)(4). Pub. L. 111-152 added par. (4).

Subsec. (g)(1). Pub. L. 111-148, §6408(b)(2)(C), inserted at end of concluding provisions “The Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2), if the Secretary determines that any employee or agent of such organization, or any provider or supplier who contracts with such organization, has engaged in any conduct described in subparagraphs (A) through (K) of this paragraph.”

Subsec. (g)(1)(H) to (K). Pub. L. 111-148, §6408(b)(2), added subpars. (H) to (K).

Subsec. (g)(2)(A). Pub. L. 111-148, §6408(b)(3), inserted “except with respect to a determination under subparagraph (E), an assessment of not more than the amount claimed by such plan or plan sponsor based upon the misrepresentation or falsified information involved,” after “for each such determination.”

2008—Subsec. (d)(6). Pub. L. 110-275, §164(d)(2), added par. (6).

Subsec. (f)(3). Pub. L. 110-275, §171(b), added par. (3).

Subsec. (f)(3)(B). Pub. L. 110-275, §172(a)(2), added subpar. (B).

Subsec. (f)(3)(C). Pub. L. 110-275, §173(b), added subpar. (C).

2003—Subsec. (d)(1). Pub. L. 108-173, §222(l)(3)(C), substituted “and costs, including allowable costs under section 1395w-27a(c) of this title” for “, costs, and computation of the adjusted community rate”.

Subsec. (d)(4)(A)(ii). Pub. L. 108-173, §900(e)(1)(I), substituted “Secretary” for “Health Care Financing Administration”.

Subsec. (e)(2)(A). Pub. L. 108-173, §222(k)(1), inserted “and a PDP sponsor under part D of this subchapter” after “organization”.

Subsec. (e)(2)(B). Pub. L. 108-173, §222(k)(2), inserted “and each PDP sponsor with a contract under part D of this subchapter” after “contract under this part”, “or sponsor’s” after “organization’s”, and “, section 1395w-101(c) of this title,” after “information”.

Subsec. (e)(2)(C). Pub. L. 108-173, §222(k)(3), inserted “and ending with fiscal year 2005” after “beginning with fiscal year 2001”, “and for each fiscal year beginning with fiscal year 2006 an amount equal to \$200,000,000,” after “\$100,000,000,” and “and section 1395w-112(b)(3)(D) of this title” after “under this paragraph”.

Subsec. (e)(2)(D)(i). Pub. L. 108-173, §222(k)(4)(A), inserted “and section 1395w-101(c) of this title” after “section 1395w-21 of this title”.

Subsec. (e)(2)(D)(ii)(III). Pub. L. 108-173, §222(k)(4)(B), struck out “and” at end.

Subsec. (e)(2)(D)(ii)(IV). Pub. L. 108-173, §222(k)(4)(C), substituted “each succeeding fiscal year before fiscal year 2006; and” for “each succeeding fiscal year.”

Subsec. (e)(2)(D)(ii)(V). Pub. L. 108-173, §222(k)(4)(D), added subcl. (V).

Subsec. (e)(2)(F). Pub. L. 108-173, §222(k)(5), added subpar. (F).

Subsec. (e)(3). Pub. L. 108-173, §237(c), added par. (3).

Subsec. (i). Pub. L. 108-173, §222(j), designated existing provisions as par. (1), inserted heading, and added par. (2).

2000—Subsec. (g)(3)(D). Pub. L. 106-554, §1(a)(6) [title VI, §623(a)], added subpar. (D).

Subsec. (i). Pub. L. 106-554, §1(a)(6) [title VI, §617(a)], added subsec. (i).

1999—Subsec. (c)(4). Pub. L. 106-113, §1000(a)(6) [title V, §513(b)(1)(B), (C)], designated existing provisions as subpar. (A), inserted heading, realigned margins, and added subpar. (B).

Pub. L. 106-113, §1000(a)(6) [title V, §513(a), (b)(1)(A)], substituted “2-year period” for “5-year period” and “except as provided in subparagraph (B) and except in such other circumstances” for “except in circumstances”.

Subsec. (e)(2)(B). Pub. L. 106-113, §1000(a)(6) [title V, §522(a)(1)], substituted “Any amounts collected shall be available without further appropriation to the Secretary for” for “Any amounts collected are authorized to be appropriated only for”.

Subsec. (e)(2)(C). Pub. L. 106-113, §1000(a)(6) [title V, §522(a)(2)], amended heading and text of subpar. (C) generally. Prior to amendment, text read as follows: “For any fiscal year, the fees authorized under subparagraph (B) are contingent upon enactment in an appropriations act of a provision specifying the aggregate amount of fees the Secretary is directed to collect in a fiscal year. Fees collected during any fiscal year under this paragraph shall be deposited and credited as offsetting collections.”

Subsec. (e)(2)(D)(ii)(II). Pub. L. 106-113, §1000(a)(6) [title V, §522(a)(3)(A)], struck out “and” after semicolon.

Subsec. (e)(2)(D)(ii)(III). Pub. L. 106-113, §1000(a)(6) [title V, §522(a)(3)(B)], substituted “; and” for “and each subsequent fiscal year.”

Subsec. (e)(2)(D)(ii)(IV). Pub. L. 106-113, §1000(a)(6) [title V, §522(a)(3)(C)], added subcl. (IV).

Subsec. (e)(2)(E). Pub. L. 106-113, §1000(a)(6) [title V, §522(a)(4)], added subpar. (E).

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108-173, set out as a note under section 1395w-21 of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by section 6408(b)(1) of Pub. L. 111-148 effective Mar. 23, 2010, and amendment by section 6408(b)(2), (3) of Pub. L. 111-148 applicable to acts committed on or after Jan. 1, 2010, see section 6408(d) of Pub. L. 111-148, set out as a note under section 1320a-7 of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110-275, title I, §164(g), July 15, 2008, 122 Stat. 2575, provided that: “The amendments made by subsections (c)(1), (d), and (e)(1) [amending this section and section 1395w-28 of this title] shall apply to plan years beginning on or after January 1, 2010, and shall apply to all specialized Medicare Advantage plans for special needs individuals regardless of when the plan first entered the Medicare Advantage program under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w-21 et seq.]”

Pub. L. 110-275, title I, §171(c), July 15, 2008, 122 Stat. 2580, provided that: “The amendments made by this section [amending this section and section 1395w-112 of this title] shall apply to plan years beginning on or after January 1, 2010.”

Pub. L. 110-275, title I, §172(b), July 15, 2008, 122 Stat. 2581, provided that: “The amendments made by this section [amending this section and section 1395w-112 of this title] shall apply to plan years beginning on or after January 1, 2010.”

Pub. L. 110-275, title I, §173(c), July 15, 2008, 122 Stat. 2581, provided that: “The amendments made by this section [amending this section and section 1395w-112 of this title] shall apply to plan years beginning on or after January 1, 2009.”

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by section 222(j), (k), (l)(3)(C) of Pub. L. 108-173 applicable with respect to plan years beginning

on or after Jan. 1, 2006, see section 223(a) of Pub. L. 108-173, set out as a note under section 1395w-21 of this title.

Amendment by section 237(c) of Pub. L. 108-173 applicable to services provided on or after Jan. 1, 2006, and contract years beginning on or after such date, see section 237(e) of Pub. L. 108-173, set out as a note under section 1320a-7b of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106-554, §1(a)(6) [title VI, §617(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-562, provided that: “The amendment made by subsection (a) [amending this section] shall apply with respect to years beginning with 2001.”

Pub. L. 106-554, §1(a)(6) [title VI, §623(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-566, provided that: “The amendment made by subsection (a) [amending this section] shall apply to terminations occurring after the date of the enactment of this Act [Dec. 21, 2000].”

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106-113, div. B, §1000(a)(6) [title V, §513(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A-383, provided that: “The amendments made by this section [amending this section] apply to contract terminations occurring before, on, or after the date of the enactment of this Act [Nov. 29, 1999].”

Pub. L. 106-113, div. B, §1000(a)(6) [title V, §522(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A-387, provided that: “The amendments made by subsection (a) [amending this section] apply to fees charged on or after January 1, 2001. The Secretary of Health and Human Services may not increase the fees charged under section 1857(e)(2) of the Social Security Act (42 U.S.C. 1395w-27(e)(2)) for the 3-month period beginning with October 2000 above the level in effect during the previous 9-month period.”

CONSTRUCTION RELATING TO ADDITIONAL EXCEPTIONS

Pub. L. 106-113, div. B, §1000(a)(6) [title V, §513(b)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A-383, provided that: “Nothing in the amendment made by paragraph (1)(C) [amending this section] shall be construed to affect the authority of the Secretary of Health and Human Services to provide for exceptions in addition to the exception provided in such amendment, including exceptions provided under Operational Policy Letter #103 (OPL99.103).”

TECHNICAL CORRECTION TO MA PRIVATE FEE-FOR-SERVICE PLANS

Pub. L. 111-148, title III, §3207, Mar. 23, 2010, 124 Stat. 459, provided that: “For plan year 2011 and subsequent plan years, to the extent that the Secretary of Health and Human Services is applying the 2008 service area extension waiver policy (as modified in the April 11, 2008, Centers for Medicare & Medicaid Services’ memorandum with the subject ‘2009 Employer Group Waiver-Modification of the 2008 Service Area Extension Waiver Granted to Certain MA Local Coordinated Care Plans’) to Medicare Advantage coordinated care plans, the Secretary shall extend the application of such waiver policy to employers who contract directly with the Secretary as a Medicare Advantage private fee-for-service plan under section 1857(i)(2) of the Social Security Act (42 U.S.C. 1395w-27(i)(2)) and that had enrollment as of October 1, 2009.”

STUDY OF MULTI-YEAR CONTRACTS

Pub. L. 108-173, title I, §107(d), Dec. 8, 2003, 117 Stat. 2171, directed the Secretary of Health and Human Services to provide for a study on the feasibility and advisability of providing for contracting with PDP sponsors and MA organizations under this part and part D of this subchapter on a multi-year basis, and to submit to Congress a report on such study not later than Jan. 1, 2007.

IMMEDIATE EFFECTIVE DATE FOR CERTAIN REQUIREMENTS FOR DEMONSTRATIONS

Pub. L. 105-33, title IV, §4002(g), Aug. 5, 1997, 111 Stat. 330, provided that: “Section 1857(e)(2) of the Social Security Act [42 U.S.C. 1395w-27(e)(2)] (requiring contribution to certain costs related to the enrollment process comparative materials) applies to demonstrations with respect to which enrollment is effected or coordinated under section 1851 of such Act [42 U.S.C. 1395w-21].”

§ 1395w-27a. Special rules for MA regional plans

(a) Regional service area; establishment of MA regions

(1) Coverage of entire MA region

The service area for an MA regional plan shall consist of an entire MA region established under paragraph (2) and the provisions of section 1395w-24(h) of this title shall not apply to such a plan.

(2) Establishment of MA regions

(A) MA region

For purposes of this subchapter, the term “MA region” means such a region within the 50 States and the District of Columbia as established by the Secretary under this paragraph.

(B) Establishment

(i) Initial establishment

Not later than January 1, 2005, the Secretary shall first establish and publish MA regions.

(ii) Periodic review and revision of service areas

The Secretary may periodically review MA regions under this paragraph and, based on such review, may revise such regions if the Secretary determines such revision to be appropriate.

(C) Requirements for MA regions

The Secretary shall establish, and may revise, MA regions under this paragraph in a manner consistent with the following:

(i) Number of regions

There shall be no fewer than 10 regions, and no more than 50 regions.

(ii) Maximizing availability of plans

The regions shall maximize the availability of MA regional plans to all MA eligible individuals without regard to health status, especially those residing in rural areas.

(D) Market survey and analysis

Before establishing MA regions, the Secretary shall conduct a market survey and analysis, including an examination of current insurance markets, to determine how the regions should be established.

(3) National plan

Nothing in this subsection shall be construed as preventing an MA regional plan from being offered in more than one MA region (including all regions).

(b) Application of single deductible and catastrophic limit on out-of-pocket expenses

An MA regional plan shall include the following:

(1) Single deductible

Any deductible for benefits under the original medicare fee-for-service program option shall be a single deductible (instead of a separate inpatient hospital deductible and a part B deductible) and may be applied differentially for in-network services and may be waived for preventive or other items and services.

(2) Catastrophic limit**(A) In-network**

A catastrophic limit on out-of-pocket expenditures for in-network benefits under the original medicare fee-for-service program option.

(B) Total

A catastrophic limit on out-of-pocket expenditures for all benefits under the original medicare fee-for-service program option.

(c) Portion of total payments to an organization subject to risk for 2006 and 2007**(1) Application of risk corridors****(A) In general**

This subsection shall only apply to MA regional plans offered during 2006 or 2007.

(B) Notification of allowable costs under the plan

In the case of an MA organization that offers an MA regional plan in an MA region in 2006 or 2007, the organization shall notify the Secretary, before such date in the succeeding year as the Secretary specifies, of—

(i) its total amount of costs that the organization incurred in providing benefits covered under the original medicare fee-for-service program option for all enrollees under the plan in the region in the year and the portion of such costs that is attributable to administrative expenses described in subparagraph (C); and

(ii) its total amount of costs that the organization incurred in providing rebatable integrated benefits (as defined in subparagraph (D)) and with respect to such benefits the portion of such costs that is attributable to administrative expenses described in subparagraph (C) and not described in clause (i) of this subparagraph.

(C) Allowable costs defined

For purposes of this subsection, the term “allowable costs” means, with respect to an MA regional plan for a year, the total amount of costs described in subparagraph (B) for the plan and year, reduced by the portion of such costs attributable to administrative expenses incurred in providing the benefits described in such subparagraph.

(D) Rebatable integrated benefits

For purposes of this subsection, the term “rebatable integrated benefits” means such non-drug supplemental benefits under subclause (I) of section 1395w-24(b)(1)(C)(ii) of this title pursuant to a rebate under such section that the Secretary determines are integrated with the benefits described in subparagraph (B)(i).

(2) Adjustment of payment**(A) No adjustment if allowable costs within 3 percent of target amount**

If the allowable costs for the plan for the year are at least 97 percent, but do not exceed 103 percent, of the target amount for the plan and year, there shall be no payment adjustment under this subsection for the plan and year.

(B) Increase in payment if allowable costs above 103 percent of target amount**(i) Costs between 103 and 108 percent of target amount**

If the allowable costs for the plan for the year are greater than 103 percent, but not greater than 108 percent, of the target amount for the plan and year, the Secretary shall increase the total of the monthly payments made to the organization offering the plan for the year under section 1395w-23(a) of this title by an amount equal to 50 percent of the difference between such allowable costs and 103 percent of such target amount.

(ii) Costs above 108 percent of target amount

If the allowable costs for the plan for the year are greater than 108 percent of the target amount for the plan and year, the Secretary shall increase the total of the monthly payments made to the organization offering the plan for the year under section 1395w-23(a) of this title by an amount equal to the sum of—

(I) 2.5 percent of such target amount; and

(II) 80 percent of the difference between such allowable costs and 108 percent of such target amount.

(C) Reduction in payment if allowable costs below 97 percent of target amount**(i) Costs between 92 and 97 percent of target amount**

If the allowable costs for the plan for the year are less than 97 percent, but greater than or equal to 92 percent, of the target amount for the plan and year, the Secretary shall reduce the total of the monthly payments made to the organization offering the plan for the year under section 1395w-23(a) of this title by an amount (or otherwise recover from the plan an amount) equal to 50 percent of the difference between 97 percent of the target amount and such allowable costs.

(ii) Costs below 92 percent of target amount

If the allowable costs for the plan for the year are less than 92 percent of the target amount for the plan and year, the Secretary shall reduce the total of the monthly payments made to the organization offering the plan for the year under section 1395w-23(a) of this title by an amount (or otherwise recover from the plan an amount) equal to the sum of—

(I) 2.5 percent of such target amount; and

(II) 80 percent of the difference between 92 percent of such target amount and such allowable costs.

(D) Target amount described

For purposes of this paragraph, the term “target amount” means, with respect to an MA regional plan offered by an organization in a year, an amount equal to—

(i) the sum of—

(I) the total monthly payments made to the organization for enrollees in the plan for the year that are attributable to benefits under the original medicare fee-for-service program option (as defined in section 1395w-22(a)(1)(B) of this title);

(II) the total of the MA monthly basic beneficiary premium collectable for such enrollees for the year; and

(III) the total amount of the rebates under section 1395w-24(b)(1)(C)(ii) of this title that are attributable to rebatable integrated benefits; reduced by

(ii) the amount of administrative expenses assumed in the bid insofar as the bid is attributable to benefits described in clause (i)(I) or (i)(III).

(3) Disclosure of information

(A) In general

Each contract under this part shall provide—

(i) that an MA organization offering an MA regional plan shall provide the Secretary with such information as the Secretary determines is necessary to carry out this subsection; and

(ii) that, pursuant to section 1395w-27(d)(2)(B) of this title, the Secretary has the right to inspect and audit any books and records of the organization that pertain to the information regarding costs provided to the Secretary under paragraph (1)(B).

(B) Restriction on use of information

Information disclosed or obtained pursuant to the provisions of this subsection may be used by officers, employees, and contractors of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this subsection.

(d) Organizational and financial requirements

(1) In general

In the case of an MA organization that is offering an MA regional plan in an MA region and—

(A) meets the requirements of section 1395w-25(a)(1) of this title with respect to at least one such State in such region; and

(B) with respect to each other State in such region in which it does not meet requirements, it demonstrates to the satisfaction of the Secretary that it has filed the necessary application to meet such requirements,

the Secretary may waive such requirement with respect to each State described in subparagraph (B) for such period of time as the

Secretary determines appropriate for the timely processing of such an application by the State (and, if such application is denied, through the end of such plan year as the Secretary determines appropriate to provide for a transition).

(2) Selection of appropriate State

In applying paragraph (1) in the case of an MA organization that meets the requirements of section 1395w-25(a)(1) of this title with respect to more than one State in a region, the organization shall select, in a manner specified by the Secretary among such States, one State the rules of which shall apply in the case of the States described in paragraph (1)(B).

(e) Repealed. Pub. L. 111-148, title X, § 10327(c)(1), Mar. 23, 2010, 124 Stat. 964

(f) Computation of applicable MA region-specific non-drug monthly benchmark amounts

(1) Computation for regions

For purposes of section 1395w-23(j)(2) of this title and this section, subject to subsection (e) of this section, the term “MA region-specific non-drug monthly benchmark amount” means, with respect to an MA region for a month in a year, the sum of the 2 components described in paragraph (2) for the region and year. The Secretary shall compute such benchmark amount for each MA region before the beginning of each annual, coordinated election period under section 1395w-21(e)(3)(B) of this title for each year (beginning with 2006).

(2) 2 components

For purposes of paragraph (1), the 2 components described in this paragraph for an MA region and a year are the following:

(A) Statutory component

The product of the following:

(i) Statutory region-specific non-drug amount

The statutory region-specific non-drug amount (as defined in paragraph (3)) for the region and year.

(ii) Statutory national market share

The statutory national market share percentage, determined under paragraph (4) for the year.

(B) Plan-bid component

The product of the following:

(i) Weighted average of MA plan bids in region

The weighted average of the plan bids for the region and year (as determined under paragraph (5)(A)).

(ii) Non-statutory market share

1 minus the statutory national market share percentage, determined under paragraph (4) for the year.

(3) Statutory region-specific non-drug amount

For purposes of paragraph (2)(A)(i), the term “statutory region-specific non-drug amount” means, for an MA region and year, an amount

equal the sum (for each MA local area within the region) of the product of—

(A) MA area-specific non-drug monthly benchmark amount under section 1395w-23(j)(1)(A) of this title for that area and year; and

(B) the number of MA eligible individuals residing in the local area, divided by the total number of MA eligible individuals residing in the region.

(4) Computation of statutory market share percentage

(A) In general

The Secretary shall determine for each year a statutory national market share percentage that is equal to the proportion of MA eligible individuals nationally who were not enrolled in an MA plan during the reference month.

(B) Reference month defined

For purposes of this part, the term “reference month” means, with respect to a year, the most recent month during the previous year for which the Secretary determines that data are available to compute the percentage specified in subparagraph (A) and other relevant percentages under this part.

(5) Determination of weighted average MA bids for a region

(A) In general

For purposes of paragraph (2)(B)(i), the weighted average of plan bids for an MA region and a year is the sum, for MA regional plans described in subparagraph (D) in the region and year, of the products (for each such plan) of the following:

(i) Monthly MA statutory non-drug bid amount

The unadjusted MA statutory non-drug monthly bid amount for the plan.

(ii) Plan’s share of MA enrollment in region

The factor described in subparagraph (B) for the plan.

(B) Plan’s share of MA enrollment in region

(i) In general

Subject to the succeeding provisions of this subparagraph, the factor described in this subparagraph for a plan is equal to the number of individuals described in subparagraph (C) for such plan, divided by the total number of such individuals for all MA regional plans described in subparagraph (D) for that region and year.

(ii) Single plan rule

In the case of an MA region in which only a single MA regional plan is being offered, the factor described in this subparagraph shall be equal to 1.

(iii) Equal division among multiple plans in year in which plans are first available

In the case of an MA region in the first year in which any MA regional plan is offered, if more than one MA regional plan is offered in such year, the factor described

in this subparagraph for a plan shall (as specified by the Secretary) be equal to—

(I) 1 divided by the number of such plans offered in such year; or

(II) a factor for such plan that is based upon the organization’s estimate of projected enrollment, as reviewed and adjusted by the Secretary to ensure reasonableness and as is certified by the Chief Actuary of the Centers for Medicare & Medicaid Services.

(C) Counting of individuals

For purposes of subparagraph (B)(i), the Secretary shall count for each MA regional plan described in subparagraph (D) for an MA region and year, the number of individuals who reside in the region and who were enrolled under such plan under this part during the reference month.

(D) Plans covered

For an MA region and year, an MA regional plan described in this subparagraph is an MA regional plan that is offered in the region and year and was offered in the region in the reference month.

(g) Election of uniform coverage determination

Instead of applying section 1395w-22(a)(2)(C) of this title with respect to an MA regional plan, the organization offering the plan may elect to have a local coverage determination for the entire MA region be the local coverage determination applied for any part of such region (as selected by the organization).

(h) Assuring network adequacy

(1) In general

For purposes of enabling MA organizations that offer MA regional plans to meet applicable provider access requirements under section 1395w-22 of this title with respect to such plans, the Secretary may provide for payment under this section to an essential hospital that provides inpatient hospital services to enrollees in such a plan where the MA organization offering the plan certifies to the Secretary that the organization was unable to reach an agreement between the hospital and the organization regarding provision of such services under the plan. Such payment shall be available only if—

(A) the organization provides assurances satisfactory to the Secretary that the organization will make payment to the hospital for inpatient hospital services of an amount that is not less than the amount that would be payable to the hospital under section 1395ww of this title with respect to such services; and

(B) with respect to specific inpatient hospital services provided to an enrollee, the hospital demonstrates to the satisfaction of the Secretary that the hospital’s costs of such services exceed the payment amount described in subparagraph (A).

(2) Payment amounts

The payment amount under this subsection for inpatient hospital services provided by a subsection (d) hospital to an enrollee in an MA

regional plan shall be, subject to the limitation of funds under paragraph (3), the amount (if any) by which—

(A) the amount of payment that would have been paid for such services under this subchapter if the enrollees were covered under the original medicare fee-for-service program option and the hospital were a critical access hospital; exceeds

(B) the amount of payment made for such services under paragraph (1)(A).

(3) Available amounts

There shall be available for payments under this subsection—

(A) in 2006, \$25,000,000; and

(B) in each succeeding year the amount specified in this paragraph for the preceding year increased by the market basket percentage increase (as defined in section 1395ww(b)(3)(B)(iii) of this title) for the fiscal year ending in such succeeding year.

Payments under this subsection shall be made from the Federal Hospital Insurance Trust Fund.

(4) Essential hospital

In this subsection, the term “essential hospital” means, with respect to an MA regional plan offered by an MA organization, a subsection (d) hospital (as defined in section 1395ww(d) of this title) that the Secretary determines, based upon an application filed by the organization with the Secretary, is necessary to meet the requirements referred to in paragraph (1) for such plan.

(Aug. 14, 1935, ch. 531, title XVIII, § 1858, as added Pub. L. 108-173, title II, § 221(c), Dec. 8, 2003, 117 Stat. 2181; amended Pub. L. 109-432, div. B, title III, § 301, Dec. 20, 2006, 120 Stat. 2990; Pub. L. 110-48, § 3, July 18, 2007, 121 Stat. 244; Pub. L. 110-173, title I, § 110, Dec. 29, 2007, 121 Stat. 2497; Pub. L. 110-275, title I, § 166, July 15, 2008, 122 Stat. 2575; Pub. L. 111-8, div. G, title I, § 1301(f), Mar. 11, 2009, 123 Stat. 829; Pub. L. 111-148, title III, § 3201(a)(2)(C), (f)(2), title X, § 10327(c)(1), Mar. 23, 2010, 124 Stat. 444, 450, 964; Pub. L. 111-152, title I, § 1102(a), Mar. 30, 2010, 124 Stat. 1040.)

AMENDMENTS

2010—Subsec. (e). Pub. L. 111-148, § 10327(c)(1), struck out subsec. (e) which related to the MA Regional Plan Stabilization Fund.

Subsec. (f)(1). Pub. L. 111-148, § 3201(a)(2)(C)(i), (f)(2)(A), which directed substitution of “1395w-23(j)(1)(B)” for “1395w-23(j)(2)” and “subsections (e) and (i)” for “subsection (e)”, respectively, was repealed by Pub. L. 111-152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (f)(3)(A). Pub. L. 111-148, § 3201(a)(2)(C)(ii), which directed substitution of “1395w-23(j)(1)(A)(i)” for “1395w-23(j)(1)(A)”, was repealed by Pub. L. 111-152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (i). Pub. L. 111-148, § 3201(f)(2)(B), which directed addition of subsec. (i), was repealed by Pub. L. 111-152, § 1102(a). As enacted, text read as follows: “For years beginning with 2014, the Secretary shall apply the performance bonuses under section 1395w-23(n) of this title (relating to bonuses for care coordination and management, quality performance, and new and low enrollment MA plans) to MA regional plans in a similar manner as such performance bonuses apply to MA plans

under such subsection.” See Effective Date of 2010 Amendment note below.

2009—Subsec. (e)(7). Pub. L. 111-8 struck out par. (7) which related to biennial GAO reports to be submitted by the Comptroller General to the Secretary and Congress.

2008—Subsec. (e)(2)(A)(i). Pub. L. 110-275 substituted “2014” for “2013” and “\$1” for “\$1,790,000,000”.

2007—Subsec. (e)(2)(A)(i). Pub. L. 110-173, which directed substitution of “the Fund during 2013, \$1,790,000,000.” for “the Fund” and all that follows, was executed by making the substitution for “the Fund—

“(I) during 2012, \$1,600,000,000; and

“(II) during 2013, \$1,790,000,000.”

to reflect the probable intent of Congress.

Pub. L. 110-48 substituted “the Fund—

“(I) during 2012, \$1,600,000,000; and

“(II) during 2013, \$1,790,000,000.”

for “the Fund during the period beginning on January 1, 2012, and ending on December 31, 2013, a total of \$3,500,000,000.”

2006—Subsec. (e)(2)(A)(i). Pub. L. 109-432 substituted “2012” for “2007” and “\$3,500,000,000” for “\$10,000,000,000”.

EFFECTIVE DATE OF 2010 AMENDMENT

Repeal of sections 3201 and 3203 of Pub. L. 111-148 and the amendments made by such sections, effective as if included in the enactment of Pub. L. 111-148, see section 1102(a) of Pub. L. 111-152, set out as a note under section 1395w-21 of this title.

EFFECTIVE DATE

Section applicable with respect to plan years beginning on or after Jan. 1, 2006, see section 223(a) of Pub. L. 108-173, set out as an Effective Date of 2003 Amendment note under section 1395w-21 of this title.

ELIMINATION OF MA REGIONAL PLAN STABILIZATION FUND; TRANSITION

Pub. L. 111-148, title X, § 10327(c)(2), Mar. 23, 2010, 124 Stat. 964, provided that: “Any amount contained in the MA Regional Plan Stabilization Fund as of the date of the enactment of this Act [Mar. 23, 2010] shall be transferred to the Federal Supplementary Medical Insurance Trust Fund.”

§ 1395w-28. Definitions; miscellaneous provisions

(a) Definitions relating to Medicare+Choice organizations

In this part—

(1) Medicare+Choice organization

The term “Medicare+Choice organization” means a public or private entity that is certified under section 1395w-26 of this title as meeting the requirements and standards of this part for such an organization.

(2) Provider-sponsored organization

The term “provider-sponsored organization” is defined in section 1395w-25(d)(1) of this title.

(b) Definitions relating to Medicare+Choice plans

(1) Medicare+Choice plan

The term “Medicare+Choice plan” means health benefits coverage offered under a policy, contract, or plan by a Medicare+Choice organization pursuant to and in accordance with a contract under section 1395w-27 of this title.

(2) Medicare+Choice private fee-for-service plan

The term “Medicare+Choice private fee-for-service plan” means a Medicare+Choice plan that—

(A) reimburses hospitals, physicians, and other providers at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk;

(B) does not vary such rates for such a provider based on utilization relating to such provider; and

(C) does not restrict the selection of providers among those who are lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established by the plan.

Nothing in subparagraph (B) shall be construed to preclude a plan from varying rates for such a provider based on the specialty of the provider, the location of the provider, or other factors related to such provider that are not related to utilization, or to preclude a plan from increasing rates for such a provider based on increased utilization of specified preventive or screening services.

(3) MSA plan

(A) In general

The term “MSA plan” means a Medicare+Choice plan that—

(i) provides reimbursement for at least the items and services described in section 1395w-22(a)(1) of this title in a year but only after the enrollee incurs countable expenses (as specified under the plan) equal to the amount of an annual deductible (described in subparagraph (B));

(ii) counts as such expenses (for purposes of such deductible) at least all amounts that would have been payable under parts A and B of this subchapter, and that would have been payable by the enrollee as deductibles, coinsurance, or copayments, if the enrollee had elected to receive benefits through the provisions of such parts; and

(iii) provides, after such deductible is met for a year and for all subsequent expenses for items and services referred to in clause (i) in the year, for a level of reimbursement that is not less than—

(I) 100 percent of such expenses, or

(II) 100 percent of the amounts that would have been paid (without regard to any deductibles or coinsurance) under parts A and B of this subchapter with respect to such expenses,

whichever is less.

(B) Deductible

The amount of annual deductible under an MSA plan—

(i) for contract year 1999 shall be not more than \$6,000; and

(ii) for a subsequent contract year shall be not more than the maximum amount of such deductible for the previous contract year under this subparagraph increased by the national per capita Medicare+Choice growth percentage under section 1395w-23(c)(6) of this title for the year.

If the amount of the deductible under clause (ii) is not a multiple of \$50, the amount shall be rounded to the nearest multiple of \$50.

(4) MA regional plan

The term “MA regional plan” means an MA plan described in section 1395w-21(a)(2)(A)(i) of this title—

(A) that has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

(B) that provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and

(C) the service area of which is one or more entire MA regions.

(5) MA local plan

The term “MA local plan” means an MA plan that is not an MA regional plan.

(6) Specialized MA plans for special needs individuals

(A) In general

The term “specialized MA plan for special needs individuals” means an MA plan that exclusively serves special needs individuals (as defined in subparagraph (B)) and that, as of January 1, 2010, meets the applicable requirements of paragraph (2), (3), or (4) of subsection (f), as the case may be.

(B) Special needs individual

The term “special needs individual” means an MA eligible individual who—

(i) is institutionalized (as defined by the Secretary);

(ii) is entitled to medical assistance under a State plan under subchapter XIX of this chapter; or

(iii) meets such requirements as the Secretary may determine would benefit from enrollment in such a specialized MA plan described in subparagraph (A) for individuals with severe or disabling chronic conditions who have one or more comorbid and medically complex chronic conditions that are substantially disabling or life threatening, have a high risk of hospitalization or other significant adverse health outcomes, and require specialized delivery systems across domains of care.

The Secretary may waive application of section 1395w-21(a)(3)(B) of this title in the case of an individual described in clause (i), (ii), or (iii) of this subparagraph and may apply rules similar to the rules of section 1395eee(c)(4) of this title for continued eligibility of special needs individuals.

(c) Other references to other terms

(1) Medicare+Choice eligible individual

The term “Medicare+Choice eligible individual” is defined in section 1395w-21(a)(3) of this title.

(2) Medicare+Choice payment area

The term “Medicare+Choice payment area” is defined in section 1395w-23(d) of this title.

(3) National per capita Medicare+Choice growth percentage

The “national per capita Medicare+Choice growth percentage” is defined in section 1395w-23(c)(6) of this title.

(4) Medicare+Choice monthly basic beneficiary premium; Medicare+Choice monthly supplemental beneficiary premium

The terms “Medicare+Choice monthly basic beneficiary premium” and “Medicare+Choice monthly supplemental beneficiary premium” are defined in section 1395w-24(a)(2) of this title.

(5) MA local area

The term “MA local area” is defined in section 1395w-23(d)(2) of this title.

(d) Coordinated acute and long-term care benefits under Medicare+Choice plan

Nothing in this part shall be construed as preventing a State from coordinating benefits under a medicaid plan under subchapter XIX of this chapter with those provided under a Medicare+Choice plan in a manner that assures continuity of a full-range of acute care and long-term care services to poor elderly or disabled individuals eligible for benefits under this subchapter and under such plan.

(e) Restriction on enrollment for certain Medicare+Choice plans

(1) In general

In the case of a Medicare+Choice religious fraternal benefit society plan described in paragraph (2), notwithstanding any other provision of this part to the contrary and in accordance with regulations of the Secretary, the society offering the plan may restrict the enrollment of individuals under this part to individuals who are members of the church, convention, or group described in paragraph (3)(B) with which the society is affiliated.

(2) Medicare+Choice religious fraternal benefit society plan described

For purposes of this subsection, a Medicare+Choice religious fraternal benefit society plan described in this paragraph is a Medicare+Choice plan described in section 1395w-21(a)(2) of this title that—

(A) is offered by a religious fraternal benefit society described in paragraph (3) only to members of the church, convention, or group described in paragraph (3)(B); and

(B) permits all such members to enroll under the plan without regard to health status-related factors.

Nothing in this subsection shall be construed as waiving any plan requirements relating to financial solvency.

(3) “Religious fraternal benefit society” defined

For purposes of paragraph (2)(A), a “religious fraternal benefit society” described in this section is an organization that—

(A) is described in section 501(c)(8) of the Internal Revenue Code of 1986 and is exempt from taxation under section 501(a) of such Act;

(B) is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches;

(C) offers, in addition to a Medicare+Choice religious fraternal benefit society plan, health coverage to individuals not en-

titled to benefits under this subchapter who are members of such church, convention, or group; and

(D) does not impose any limitation on membership in the society based on any health status-related factor.

(4) Payment adjustment

Under regulations of the Secretary, in the case of individuals enrolled under this part under a Medicare+Choice religious fraternal benefit society plan described in paragraph (2), the Secretary shall provide for such adjustment to the payment amounts otherwise established under section 1395w-24 of this title as may be appropriate to assure an appropriate payment level, taking into account the actuarial characteristics and experience of such individuals.

(f) Requirements regarding enrollment in specialized MA plans for special needs individuals

(1) Requirements for enrollment

In the case of a specialized MA plan for special needs individuals (as defined in subsection (b)(6) of this section), notwithstanding any other provision of this part and in accordance with regulations of the Secretary and for periods before January 1, 2019, the plan may restrict the enrollment of individuals under the plan to individuals who are within one or more classes of special needs individuals.

(2) Additional requirements for institutional SNPS

In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(i), the applicable requirements described in this paragraph are as follows:

(A) Each individual that enrolls in the plan on or after January 1, 2010, is a special needs individuals described in subsection (b)(6)(B)(i). In the case of an individual who is living in the community but requires an institutional level of care, such individual shall not be considered a special needs individual described in subsection (b)(6)(B)(i) unless the determination that the individual requires an institutional level of care was made—

(i) using a State assessment tool of the State in which the individual resides; and

(ii) by an entity other than the organization offering the plan.

(B) The plan meets the requirements described in paragraph (5).

(C) If applicable, the plan meets the requirement described in paragraph (7).

(3) Additional requirements for dual SNPS

In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii), the applicable requirements described in this paragraph are as follows:

(A) Each individual that enrolls in the plan on or after January 1, 2010, is a special needs individuals¹ described in subsection (b)(6)(B)(ii).

(B) The plan meets the requirements described in paragraph (5).

¹ So in original. Probably should be “individual”.

(C) The plan provides each prospective enrollee, prior to enrollment, with a comprehensive written statement (using standardized content and format established by the Secretary) that describes—

(i) the benefits and cost-sharing protections that the individual is entitled to under the State Medicaid program under subchapter XIX; and

(ii) which of such benefits and cost-sharing protections are covered under the plan.

Such statement shall be included with any description of benefits offered by the plan.

(D) The plan has a contract with the State Medicaid agency to provide benefits, or arrange for benefits to be provided, for which such individual is entitled to receive as medical assistance under subchapter XIX. Such benefits may include long-term care services consistent with State policy.

(E) If applicable, the plan meets the requirement described in paragraph (7).

(4) Additional requirements for severe or disabling chronic condition SNPS

In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(iii), the applicable requirements described in this paragraph are as follows:

(A) Each individual that enrolls in the plan on or after January 1, 2010, is a special needs individual described in subsection (b)(6)(B)(iii).

(B) The plan meets the requirements described in paragraph (5).

(C) If applicable, the plan meets the requirement described in paragraph (7).

(5) Care management requirements for all SNPS

The requirements described in this paragraph are that the organization offering a specialized MA plan for special needs individuals—

(A) have in place an evidenced-based model of care with appropriate networks of providers and specialists; and

(B) with respect to each individual enrolled in the plan—

(i) conduct an initial assessment and an annual reassessment of the individual's physical, psychosocial, and functional needs;

(ii) develop a plan, in consultation with the individual as feasible, that identifies goals and objectives, including measurable outcomes as well as specific services and benefits to be provided; and

(iii) use an interdisciplinary team in the management of care.

(6) Transition and exception regarding restriction on enrollment

(A) In general

Subject to subparagraph (C), the Secretary shall establish procedures for the transition of applicable individuals to—

(i) a Medicare Advantage plan that is not a specialized MA plan for special needs individuals (as defined in subsection (b)(6)); or

(ii) the original Medicare fee-for-service program under parts A and B.

(B) Applicable individuals

For purposes of clause (i), the term 'applicable individual' means an individual who—

(i) is enrolled under a specialized MA plan for special needs individuals (as defined in subsection (b)(6)); and

(ii) is not within the 1 or more of the classes of special needs individuals to which enrollment under the plan is restricted to.

(C) Exception

The Secretary shall provide for an exception to the transition described in subparagraph (A) for a limited period of time for individuals enrolled under a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii) who are no longer eligible for medical assistance under subchapter XIX.

(D) Timeline for initial transition

The Secretary shall ensure that applicable individuals enrolled in a specialized MA plan for special needs individuals (as defined in subsection (b)(6)) prior to January 1, 2010, are transitioned to a plan or the program described in subparagraph (A) by not later than January 1, 2013.

(7) Authority to require special needs plans be NCQA approved

For 2012 and subsequent years, the Secretary shall require that a Medicare Advantage organization offering a specialized MA plan for special needs individuals be approved by the National Committee for Quality Assurance (based on standards established by the Secretary).

(g) Special rules for senior housing facility plans

(1) In general

In the case of a Medicare Advantage senior housing facility plan described in paragraph (2), notwithstanding any other provision of this part to the contrary and in accordance with regulations of the Secretary, the service area of such plan may be limited to a senior housing facility in a geographic area.

(2) Medicare Advantage senior housing facility plan described

For purposes of this subsection, a Medicare Advantage senior housing facility plan is a Medicare Advantage plan that—

(A) restricts enrollment of individuals under this part to individuals who reside in a continuing care retirement community (as defined in section 1395w-22(l)(4)(B) of this title);

(B) provides primary care services onsite and has a ratio of accessible physicians to beneficiaries that the Secretary determines is adequate;

(C) provides transportation services for beneficiaries to specialty providers outside of the facility; and

(D) has participated (as of December 31, 2009) in a demonstration project established by the Secretary under which such a plan was offered for not less than 1 year.

(Aug. 14, 1935, ch. 531, title XVIII, § 1859, as added Pub. L. 105-33, title IV, § 4001, Aug. 5, 1997, 111 Stat. 325; amended Pub. L. 106-113, div. B, § 1000(a)(6) [title V, § 523], Nov. 29, 1999, 113 Stat. 1536, 1501A-387; Pub. L. 108-173, title II, §§ 221(b)(1), (d)(2), 231(b), (c), Dec. 8, 2003, 117 Stat. 2180, 2193, 2207, 2208; Pub. L. 110-173, title I, § 108(a), Dec. 29, 2007, 121 Stat. 2496; Pub. L. 110-275, title I, §§ 162(b), 164(a), (c)(1), (d)(1), (e)(1), July 15, 2008, 122 Stat. 2571-2574; Pub. L. 111-148, title III, §§ 3205(a), (c), (e), (g), 3208(a), Mar. 23, 2010, 124 Stat. 457-459; Pub. L. 112-240, title VI, § 607, Jan. 2, 2013, 126 Stat. 2349; Pub. L. 113-67, div. B, title I, § 1107, Dec. 26, 2013, 127 Stat. 1197; Pub. L. 113-93, title I, § 107, Apr. 1, 2014, 128 Stat. 1043; Pub. L. 114-10, title II, § 206, Apr. 16, 2015, 129 Stat. 145.)

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (e)(3)(A), is classified generally to Title 26, Internal Revenue Code.

AMENDMENTS

2015—Subsec. (f)(1). Pub. L. 114-10 substituted “2019” for “2017”.

2014—Subsec. (f)(1). Pub. L. 113-93 substituted “2017” for “2016”.

2013—Subsec. (f)(1). Pub. L. 113-67 substituted “2016” for “2015”.

Subsec. (f)(1). Pub. L. 112-240 substituted “2015” for “2014”.

2010—Subsec. (f)(1). Pub. L. 111-148, § 3205(a), substituted “2014” for “2011”.

Subsec. (f)(2)(C). Pub. L. 111-148, § 3205(e)(1), added subpar. (C).

Subsec. (f)(3)(E). Pub. L. 111-148, § 3205(e)(2), added subpar. (E).

Subsec. (f)(4)(C). Pub. L. 111-148, § 3205(e)(3), added subpar. (C).

Subsec. (f)(5). Pub. L. 111-148, § 3205(g), struck out “described in subsection (b)(6)(B)(i)” after “individuals” in introductory provisions.

Subsec. (f)(6), (7). Pub. L. 111-148, § 3205(c), (e)(4), added pars. (6) and (7).

Subsec. (g). Pub. L. 111-148, § 3208(a), added subsec. (g).

2008—Subsec. (b)(2). Pub. L. 110-275, § 162(b), inserted concluding provisions.

Subsec. (b)(6)(A). Pub. L. 110-275, § 164(c)(1)(A), inserted “and that, as of January 1, 2010, meets the applicable requirements of paragraph (2), (3), or (4) of subsection (f), as the case may be” before period at end.

Subsec. (b)(6)(B)(iii). Pub. L. 110-275, § 164(e)(1), inserted “who have one or more comorbid and medically complex chronic conditions that are substantially disabling or life threatening, have a high risk of hospitalization or other significant adverse health outcomes, and require specialized delivery systems across domains of care” before period at end.

Subsec. (f). Pub. L. 110-275, § 164(c)(1)(B)(ii), (iii), designated existing provisions as par. (1), inserted par. heading, and added pars. (2) to (4).

Pub. L. 110-275, § 164(c)(1)(B)(i), amended heading generally. Prior to amendment, heading read “Restriction on enrollment for specialized MA plans for special needs individuals”.

Pub. L. 110-275, § 164(a), substituted “2011” for “2010”. Subsec. (f)(5). Pub. L. 110-275, § 164(d)(1), added par. (5).

2007—Subsec. (f). Pub. L. 110-173 substituted “2010” for “2009”.

2003—Subsec. (b)(4), (5). Pub. L. 108-173, § 221(b)(1), added pars. (4) and (5).

Subsec. (b)(6). Pub. L. 108-173, § 231(b), added par. (6).

Subsec. (c)(5). Pub. L. 108-173, § 221(d)(2), added par. (5).

Subsec. (f). Pub. L. 108-173, § 231(c), added subsec. (f).

1999—Subsec. (e)(2). Pub. L. 106-113 substituted “section 1395w-21(a)(2) of this title” for “section 1395w-21(a)(2)(A) of this title” in introductory provisions.

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108-173, set out as a note under section 1395w-21 of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111-148, title III, § 3208(b), Mar. 23, 2010, 124 Stat. 460, provided that: “The amendment made by this section [amending this section] shall take effect on January 1, 2010, and shall apply to plan years beginning on or after such date.”

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by section 164(c)(1), (d)(1), (e)(1) of Pub. L. 110-275 applicable to plan years beginning on or after Jan. 1, 2010, and applicable to all specialized Medicare Advantage plans for special needs individuals regardless of when the plan first entered the Medicare Advantage program under this part, see section 164(g) of Pub. L. 110-275, set out as a note under section 1395w-27 of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by section 221(b)(1), (d)(2) of Pub. L. 108-173 applicable with respect to plan years beginning on or after Jan. 1, 2006, see section 223(a) of Pub. L. 108-173, set out as a note under section 1395w-21 of this title.

Amendment by section 231(b), (c) of Pub. L. 108-173 effective Dec. 8, 2003, see section 231(f)(1) of Pub. L. 108-173, set out as a note under section 1395w-21 of this title.

REGULATIONS

Pub. L. 108-173, title II, § 231(f)(2), Dec. 8, 2003, 117 Stat. 2208, provided that: “No later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall issue final regulations to establish requirements for special needs individuals under section 1859(b)(6)(B)(iii) of the Social Security Act [42 U.S.C. 1395w-28(b)(6)(B)(iii)], as added by subsection (b).”

AUTHORIZATION TO OPERATE; RESOURCES FOR STATE MEDICAID AGENCIES; CONTRACTING REQUIREMENTS

Pub. L. 110-275, title I, § 164(c)(2)-(4), July 15, 2008, 122 Stat. 2573, as amended by Pub. L. 111-148, title III, § 3205(d), Mar. 23, 2010, 124 Stat. 458, provided that:

“(2) AUTHORITY TO OPERATE BUT NO SERVICE AREA EXPANSION FOR DUAL SNPS THAT DO NOT MEET CERTAIN REQUIREMENTS.—Notwithstanding subsection (f) of section 1859 of the Social Security Act (42 U.S.C. 1395w-28), during the period beginning on January 1, 2010, and ending on December 31, 2012, in the case of a specialized Medicare Advantage plan for special needs individuals described in subsection (b)(6)(B)(ii) of such section, as amended by this section, that does not meet the requirement described in subsection (f)(3)(D) of such section, the Secretary of Health and Human Services—

“(A) shall permit such plan to be offered under part C of title XVIII of such Act [42 U.S.C. 1395w-21 et seq.]; and

“(B) shall not permit an expansion of the service area of the plan under such part C.

“(3) RESOURCES FOR STATE MEDICAID AGENCIES.—The Secretary of Health and Human Services shall provide for the designation of appropriate staff and resources that can address State inquiries with respect to the coordination of State and Federal policies for specialized MA plans for special needs individuals described in sec-

tion 1859(b)(6)(B)(ii) of the Social Security Act (42 U.S.C. 1395w-28(b)(6)(B)(ii)), as amended by this section.

“(4) NO REQUIREMENT FOR CONTRACT.—Nothing in the provisions of, or amendments made by, this subsection [amending this section] shall require a State to enter into a contract with a Medicare Advantage organization with respect to a specialized MA plan for special needs individuals described in section 1859(b)(6)(B)(ii) of the Social Security Act (42 U.S.C. 1395w-28(b)(6)(B)(ii)), as amended by this section.”

PANEL OF CLINICAL ADVISORS TO DETERMINE CONDITIONS

Pub. L. 110-275, title I, §164(e)(2), July 15, 2008, 122 Stat. 2574, provided that: “The Secretary of Health and Human Services shall convene a panel of clinical advisors to determine the conditions that meet the definition of severe and disabling chronic conditions under section 1859(b)(6)(B)(iii) of the Social Security Act (42 U.S.C. 1395w-28(b)(6)(B)(iii)), as amended by paragraph (1). The panel shall include the Director of the Agency for Healthcare Research and Quality (or the Director’s designee).”

NO EFFECT ON MEDICAID BENEFITS FOR DUALS

Pub. L. 110-275, title I, §164(h), July 15, 2008, 122 Stat. 2575, provided that: “Nothing in the provisions of, or amendments made by, this section [amending this section and sections 1395w-22 and 1395w-27 of this title and enacting provisions set out as notes under this section and sections 1395w-21, 1395w-22, and 1395w-27 of this title] shall affect the benefits available under the Medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] for special needs individuals described in section 1859(b)(6)(B)(ii) of such Act (42 U.S.C. 1395w-28(b)(6)(B)(ii)).”

AUTHORITY TO DESIGNATE OTHER PLANS AS SPECIALIZED MA PLANS

Secretary of Health and Human Services authorized, in promulgating regulations to carry out subsection (b)(6) of this section, to provide, notwithstanding subsection (b)(6)(A) of this section, for the offering of specialized MA plans for special needs individuals by MA plans that disproportionately serve special needs individuals, see section 231(d) of Pub. L. 108-173, set out as a note under section 1395w-21 of this title.

§ 1395w-29. Repealed. Pub. L. 111-152, title I, § 1102(f), Mar. 30, 2010, 124 Stat. 1046

Section, act Aug. 14, 1935, ch. 531, title XVIII, §1860C-1, as added Pub. L. 108-173, title II, §241(a), Dec. 8, 2003, 117 Stat. 2214; amended Pub. L. 111-148, title III, §3201(a)(2)(D), Mar. 23, 2010, 124 Stat. 444; Pub. L. 111-152, title I, §1102(a), Mar. 30, 2010, 124 Stat. 1040, related to comparative cost adjustment program.

PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM

PRIOR PROVISIONS

A prior part D of this subchapter, consisting of section 1395x et seq., was redesignated part E of this subchapter.

SUBPART 1—PART D ELIGIBLE INDIVIDUALS AND PRESCRIPTION DRUG BENEFITS

§ 1395w-101. Eligibility, enrollment, and information

(a) Provision of qualified prescription drug coverage through enrollment in plans

(1) In general

Subject to the succeeding provisions of this part, each part D eligible individual (as defined in paragraph (3)(A)) is entitled to obtain

qualified prescription drug coverage (described in section 1395w-102(a) of this title) as follows:

(A) Fee-for-service enrollees may receive coverage through a prescription drug plan

A part D eligible individual who is not enrolled in an MA plan may obtain qualified prescription drug coverage through enrollment in a prescription drug plan (as defined in section 1395w-151(a)(14) of this title).

(B) Medicare Advantage enrollees

(i) Enrollees in a plan providing qualified prescription drug coverage receive coverage through the plan

A part D eligible individual who is enrolled in an MA-PD plan obtains such coverage through such plan.

(ii) Limitation on enrollment of MA plan enrollees in prescription drug plans

Except as provided in clauses (iii) and (iv), a part D eligible individual who is enrolled in an MA plan may not enroll in a prescription drug plan under this part.

(iii) Private fee-for-service enrollees in MA plans not providing qualified prescription drug coverage permitted to enroll in a prescription drug plan

A part D eligible individual who is enrolled in an MA private fee-for-service plan (as defined in section 1395w-28(b)(2) of this title) that does not provide qualified prescription drug coverage may obtain qualified prescription drug coverage through enrollment in a prescription drug plan.

(iv) Enrollees in MSA plans permitted to enroll in a prescription drug plan

A part D eligible individual who is enrolled in an MSA plan (as defined in section 1395w-28(b)(3) of this title) may obtain qualified prescription drug coverage through enrollment in a prescription drug plan.

(2) Coverage first effective January 1, 2006

Coverage under prescription drug plans and MA-PD plans shall first be effective on January 1, 2006.

(3) Definitions

For purposes of this part:

(A) Part D eligible individual

The term “part D eligible individual” means an individual who is entitled to benefits under part A of this subchapter or enrolled under part B of this subchapter.

(B) MA plan

The term “MA plan” has the meaning given such term in section 1395w-28(b)(1) of this title.

(C) MA-PD plan

The term “MA-PD plan” means an MA plan that provides qualified prescription drug coverage.

(b) Enrollment process for prescription drug plans

(1) Establishment of process

(A) In general

The Secretary shall establish a process for the enrollment, disenrollment, termination,